

**GENERAL AGENCY INDICATORS & GUIDANCE**  
**Review Year July 2008 through June 2009**

The Guidance is provided as a resource to assist agencies with understanding Key Indicators. The Guidance is not intended to be, nor should be, considered as the ultimate defining resource. It should be, as inferred by its title, a GUIDANCE designed to assist. State and Federal standards including policies and procedures are the ultimate resources for establishing the requirements for an Indicator.

G1	SERVICE COORDINATION SUPPORT PLAN	GUIDANCE
G1-01 R	The Plan is developed and signed by the Service Coordinator every 365 days.	<p>Review current Plan in the person's record. A current Plan must be present and signed by a Service Coordinator. A current Plan is defined as one completed within the last 365 days. When there is a leap year, the plan date would be calculated accordingly to ensure the plan is developed and signed within 365 days. Please note that Support Plans with effective dates of 3/1/07 through 2/29/08 will need to be backed-up two days because of Leap year/366 days. Example: If last year's Plan was 4/5/07, this year's Plan would have to be done by 4/3/08.</p> <p>Plans completed on or after 3/14/08 must be keyed into the Consumer Data and Support System (CDSS) using the Consumer Assessment and Planning (CAP) module. Note: Plans may have been keyed into the system as early as 02/05/08 depending on a provider's training date but all plans completed on or after 3/14/08 must have been keyed into the CAP module on CDSS.</p> <p>For those receiving Level 1 Service Coordination, a plan must be completed:</p> <ul style="list-style-type: none"> <li>• By the 45th calendar day following the determination of eligibility for SCDDSN services</li> <li>• Within 365 days of the last plan</li> <li>• By the 45th day of being transferred from Level II Service Coordination</li> <li>• For people moving from Level II to Level I Service Coordination and the plan is less than 365 days old, the plan must be reviewed with the person/legal guardian, updated, signed and dated by the SC</li> <li>• By the 45th day of being transferred from Early Intervention</li> <li>• Before MR/RD Waiver or HASCI Waiver Services are authorized/provided.</li> <li>• Signed and dated by the Service Coordinator</li> </ul> <p>Source: Support Plan Instructions and the Service Coordination Standards.</p>
G1-02	Needs and interventions reflected in the Plan must be justified by formal or informal assessment information in the record.	<p>Review the Service Coordination record to determine if formal or informal assessment information is available to justify the "need" noted on the Plan for which interventions are being implemented. The assessment information (formal or informal) must be current and accurate. Formal and/or informal assessments may include information provided by the person and/or his/her caregivers about the person's current situation, medical status, school records or other formalized assessment tools.</p> <p>At the time of annual planning, the <i>SCDDSN Service Coordination Annual Assessment</i> will be used to identify needs and justify services/interventions reflected in the Support Plan (beginning no later than 3/14/08, assessments will be keyed into the CAP module of CDSS) Information from providers currently providing services should be considered in planning. The record should reflect attempts to secure information from all current service providers. Attempts should be made in sufficient time prior to planning so that information can be secured. If the person is enrolled in the HASCI or MR/RD Waiver, then formal or informal assessments and recommendations for all Waiver services will be present.</p> <p>Needs assessment during the course of the year <b>outside</b> of annual planning will be documented in the service notes. When needs are identified, the Support Plan will be updated accordingly.</p> <p>An assessment of the person's needs must be:</p> <ol style="list-style-type: none"> <li>a. initiated within 5 working days of the initial home visit</li> </ol>

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		<ul style="list-style-type: none"> <li>b. completed prior to the initiation of the Plan</li> <li>c. completed within 6 months of the first reported case management activity</li> <li>d. completed at least annually</li> <li>e. completed when there is a crisis (crisis intervention) or when interventions are needed to address specific and identifiable problems/issues (regular intervention)</li> <li>f. completed when there are changes in level of Service Coordination as indicated in the Level I/Level II Service Coordination policy (must use the Level I/Level II Service Coordination Assessment)</li> </ul> <p>Source: "Guidelines on How to Complete the SCDDSN Annual Service Coordination Assessment", Support Plan Instructions, Service Coordination Standards and Waiver manuals for further details pertaining to needs assessment. Supports CQL Organizing Principles- S2, S3.</p>
G1-03	Record must reflect that the person or his/her legal guardian (if legal guardian is applicable) was afforded the opportunity to participate in planning.	<p>Review the Service Coordination record to ensure the person or his/her legal guardian (if legal guardian is applicable) was afforded the opportunity to participate in planning. This can be demonstrated in the record by inviting the person or his/her legal guardian to meet to discuss plans, by scheduling the meeting (If a meeting is chosen) at a time and location that allows for participation, by soliciting input prior to the actual meeting, or by allowing participation in the meeting by phone or other means. The requirement is that the opportunity be afforded, not that participation occur.</p> <p>A note indicating the person's/legal guardian's (if legal guardian is applicable) mere presence at a meeting does not alone justify participation in planning. Also, a note indicating the person/legal guardian's (if legal guardian is applicable) choice <i>not</i> to have a plan meeting does not alone justify participation.</p> <p>Source: Support Plan Instructions Supports CQL Basic Assurances - A6 and Organizing Principles- L1, L2, L3, S3.</p>
G1-04	The Plan identifies assessed needs, interventions, and appropriate funding sources (in relation to the identified service / intervention).	<p>Review all Plans in effect during the review period to determine if needs are identified on the plan as assessed <b>and</b> that interventions are identified to address assessed "needs".</p> <p>If needs are identified and not on the plan, there must be documentation present to show why those assessed needs are not on the Plan. During annual planning, Service Coordinators may use the CAP module "Worksheet" as a means for prioritizing and explaining needs. It is acceptable to <i>not</i> address every single need identified on the SCDDSN Service Coordination Annual Assessment provided that <b>at least</b> one need is addressed on the Plan from every domain of the assessment/area of a person's life. If needs were identified in a domain/area of the person's life using the SCDDSN Annual Assessment, but <i>none</i> of those identified are addressed, explanation <i>must</i> be present to support the decision for that domain/area of the person's life not being on the plan.</p> <p>When needs are addressed on the plan, there must also be interventions to address the need. Interventions must have a logical connection to the need and the person/legal guardian (if legal guardian is applicable) must agree that the action/intervention will be implemented.</p> <p>When services/interventions are identified, appropriate funding sources will be identified in relation to the identified service/intervention. Review the person's "current resources" identified in the SCDDSN Service Coordination Annual Assessment (or the service notes when needs assessment occurs outside of planning and resources have changed from those noted on the Plan) to determine what resources the person has. Compare the person's resources to the services/interventions noted on the Plan to determine if the appropriate funding</p>

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		<p>source is listed for the service/intervention to be/being provided.</p> <p>Source: <i>"Guidelines for Completion of the SCDDSN Service Coordination Annual Assessment"</i> for defined resources and the Service Coordination Standards glossaries. Also, reference Service Coordination Standards and Waiver manuals.</p>
G1-05	The Plan is amended / updated as needed.	<p>Review all plans and service notes in effect during the review period to determine if:</p> <ol style="list-style-type: none"> <li>updates are made as needed when new service needs or interventions are identified,</li> <li>when there have been significant changes in the person's life,</li> <li>when a service is determined to not be effective,</li> <li>a need/s has/have been met ,</li> <li>or the person is not satisfied.</li> </ol> <p>Amendments/updates/needs/changes are completed when any aspect of the "Needs/Interventions" page/s of the Support Plan changes or if a new need is identified. There will be a notation in the service note noting any change to the Plan with a detailed explanation of the change in the record (it is acceptable to have a brief service note provided the change is explained in detail on the "needs change" form). For new needs identified during the course of the year, needs assessment and identification of the need will be in the service notes and, if applicable, a new "needs/interventions" page will be added to the plan to note any additions to the plan.</p> <p>A plan must be current at all times (All needs must reflect an accurate start date).</p> <p>Source: Support Plan Instructions, Service Coordination Standards and Waiver manuals. Supports CQL Organizing Principles- S2, S3.</p>
G1-06	The Person / Legal Guardian was provided a copy of the Plan.	<p>Review the service notes/file to verify that the person and/or legal guardian was provided a copy of the Plan. Proof of provision of the Plan document to the person/legal guardian may be found in the service notes or correspondences section of the file. Provision of the Support Plan to the person/legal guardian (if legal guardian is applicable) may be provided via mail, email, or hand delivered as long as documentation (inclusive of the date) is present to show the person/legal guardian was provided a copy of the plan.</p> <p>Source: Service Coordination Standards Supports CQL Basic Assurances - A6 and Organizing Principles- L1, L2, L3, S3.</p>
G1-07	The Plan is monitored at least quarterly (Quarterly Plan Review).	<p>The Plan is monitored at least quarterly (Quarterly Plan Review). Review all Plans in effect during the review period to determine if all needs and interventions were monitored as often as needed, but at least quarterly and to ensure that needs were implemented as prescribed in the Plan. Documentation for each need and intervention should include recommendations for continued implementation, revision or discontinuation. Furthermore, ensure that any new needs identified during the quarterly Plan review are added to the person's Plan.</p> <p>Beginning March 14, 2008, <b>all</b> monitoring will be completed on the CAP module of CDSS, and filed with the Support Plan. A service note will be completed to reference monitoring of needs whether it is a quarterly monitoring, monthly monitoring, or one-time monitoring of a need. Monitoring forms utilized on the CAP and required by the "Support Plan" instructions include all of the necessary components of monitoring. Service notes may be brief (must be present for reporting purposes) and will at least reference monitoring forms.</p> <p>Refer to Service Coordination Standards and Support Plan Instructions</p>
G1-08	Information about the person's plan for what to do in emergency	<p>Review the Plan to ensure that information is present regarding the Emergency Plan for the person. Emergency Plans must include the following components on all Plans beginning 7/1/08:</p>

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	situations is included in the Plan.	<p>a. For people residing in SCDDSN sponsored residential settings: Documentation on the Plan will include, but not limited to:</p> <ol style="list-style-type: none"> <li>1. a statement regarding the location of the detailed emergency disaster plan</li> </ol> <p>b. For people in all other settings (Including non-DDSN sponsored residential settings): Documentation on the Plan will include, but not limited to:</p> <ol style="list-style-type: none"> <li>1. what plans have been made for an emergency/natural disaster or loss of primary caregiver</li> <li>2. what transportation services/supports will be used and/or how the person will be transported</li> <li>3. where the person will evacuate to if an evacuation is required</li> </ol> <p>Source: “<i>Questions and Answers on the Support Plan and Annual Assessment</i>” September 2007” and the Service Coordination Standards update 4/2008 -- this is a CMS requirement. Supports CQL Basic Assurances - A4 and Organizing Principles- S3, S4.</p>

G2	SERVICE COORDINATION	GUIDANCE
G2-01	Service Coordination activity reflects monitoring to address identified needs and personal goals as prescribed/required.	<p>Review all documentation in the Service Coordination record to determine if needs during the review period were addressed. If identified needs warrant, the Plan should reflect if monitoring is required in excess of the minimum requirements (i.e., excess of quarterly). Additional monitoring may mean an increase in the frequency of monitoring (e.g. monitoring more frequently than quarterly for some or all needs), an increase in intensity of monitoring (e.g., face-to-face monitoring at regular intervals versus the minimum 1 face-to-face visit required annually), or a combination of intensity and frequency. If increased monitoring is needed, then the frequency of and intensity of the monitoring should be on the Plan (indicated on the first page of the Support Plan). Review contact notes, Quarterly Plan Reviews, and Plan revisions to determine if the person has received ongoing needs assessment and planning which is prescriptive to address identified needs.</p> <p>Source: Service Coordination Standards and the Waiver manuals. Supports CQL Organizing Principles L3, S2, S3.</p>
G2-02	Face-to-face contacts occur as required.	<p>For Level I Service Coordination, review service notes in the Service Coordination record to determine if the person served has received face-to-face-contact by the Service Coordinator at least once per Plan year during each 365-day period. The Service Coordinator must perform a core job function during face-to-face visits. The Service Coordinator must document in the service notes the visit and that the face-to-face was with the person receiving services and not just family and/or the legal guardian (if legal guardian is applicable).</p> <p>Source: Service Coordination Standards</p>
G2-03	Level II Service Coordination DDSN requirements are met. (For Level II Service Coordination recipients only)	<p>Review the record and check for the following:</p> <ul style="list-style-type: none"> <li>• The agreement for Level II Service Coordination form is present in the file with necessary signature and date. For children and adults adjudicated incompetent the current legal guardian must sign the form. For those 18 years and older or those with a name change, a new Agreement form should be signed by the person. Documentation should support that a signed copy was given to the person or his/her legal guardian. If the person/legal guardian cannot be located and the SC anticipates future contact from the person/legal guardian, 3 legitimate attempts to contact the person/legal guardian must be made and documented in the service notes and the SCS's and SC's signatures are sufficient to move the person to Level II.</li> <li>• Annual contacts are made (every 365 days) or more as determined by the person.</li> <li>• Review service notes in the Service Coordination record to determine if the person has received at least one annual contact within 365 days of the last contact or date of placement on Level II. An annual contact requires the Service Coordinator to review the last Plan prior to placement on Level II SC, make contact with any DDSN or QPL providers, and to contact the person or legal guardian to determine if Level II Service Coordination is still appropriate. The service notes also verify the person's demographic information, current situation, and general health status.</li> </ul> <p>Source: Level I/Level II Service Coordination Policy</p>
G2-04	Intake procedures / activities meet requirements as defined in the Service Coordination Standards (2007)	<p>Review all indicators and guidance in the Service Coordination Standards pages 15-19 to determine compliance. Citations should be listed in accordance with the Standards and indicate specifically what is being cited under the Intake requirements.</p> <p>Note: It is very important that, for people in critical or urgent status, the record reflect continuous and accelerated attempts to exceed required timeframes.</p> <p>Source: Service Coordination Standards</p>
G2-05	Service Coordination	Review the Service Coordination record to determine if records include the following:

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	records are maintained and include required information.	<ul style="list-style-type: none"> <li>Needs assessment information (Documentation that needs were identified may be in the service notes and/or on the Plan. Prior to 1/2007, needs may be identified via the SCDDSN Individual Global Assessment tool. After 7/1/07, Service Coordinators are required to complete the SCDDSN Individual Global Assessment tool)</li> <li>A current Single/Support Plan (After 7/1/07 the Support Plan will be used)</li> <li>Medical information or Records (medical information will be included in the context of the Plan or in needs assessment information/tool. Medical information, at a minimal, must include the person's medical status. Records may be included, if applicable.</li> <li>Most recent Psychological Assessment (if applicable, i.e. a person may not have a psychological assessment if they are served by the HASCI division)</li> <li>Current IEP (for school age children)</li> <li>SCDDSN Eligibility Determination/Correspondence (correspondence from the Consumer Assessment Team regarding the person's eligibility. If prior to 9/01, information may not be available from the Consumer Assessment Team; therefore, absence of eligibility information prior to 9/01 should not be held against the provider)</li> <li>A valid Service Agreement (review most recently completed Service Agreement to assure that it is dated and signed. For children and for adult's adjudicated incompetent, the current legal guardian must sign the form. For those 18 years and older or those with a name change, a new Service Agreement should be signed by the person. The most current Service Agreement must be filed in the primary case record that is signed and dated by the appropriate party. Score "Not Met" if there is not a Service Agreement in the primary case record and/or it is not signed and dated by the appropriate party. <b>IF THERE IS NOT A SERVICE AGREEMENT IN THE PRIMARY CASE RECORD, SCORE "Not Met" ON ALL APPLICABLE KEY INDICATORS.</b></li> <li>Service Notes (when reviewing service notes, check to make sure that service notes are typed or handwritten in black or dark blue ink, legible, clear (especially, but not limited to, multiple actions which support the same activity and which occurred on the same day are incorporated into one service notes), in chronological order, entries dated and signed with the date, Service Coordinator's name and title or initials (a signature/initial sheet must be maintained at the Service Coordination provider's office), if abbreviations or symbols are used, there is a list of any abbreviations or symbols maintained at the Service Coordination provider's office, persons referenced are identified by their relationship to the person receiving services either at least once on each page or on a separate list located in each record, proper error correction procedures are followed if errors have occurred and no correction fluid or erasable ink was used)</li> </ul> <p>Source: Service Coordination Standards</p>
G2-06	The CDSS/STS is up to date.	<p>Review the STS Master Report also known as feedback document. This document represents a summary of data in the services module of the old STS data system and data in the new CDSS data system. Compare this document to the plan, services, service notes and other documentation available in the person's primary case record. The feedback document must be reviewed for consistency with other documentation in the record. The feedback document is composed of 8 data Segments representing Intake, Eligibility, Services Waiting List, Receiving Services, Miscellaneous Data, Waiver Information, Head Injury, and Spinal Cord Injury.</p> <p>Source: Service Coordination Manual and CDSS/STS data systems</p>

G2	SERVICE COORDINATION	GUIDANCE
G2-07	<p>The Service Coordinator has provided information for, offered choice of and monitored a person's access to health care services/providers (inclusive of primary health care provider / physician) when health care needs are identified.</p>	<p>As specific needs arise or are identified for health care, the Service Coordination record reflects that the person's options for health care and choice of health care providers were discussed and offered to the person/legal guardian ( if legal guardian is applicable) by the Service Coordinator (upon notification of the health care need/status change) and that the Service Coordinator has monitored to confirm that the person has accessed health care to address any unresolved health care needs or lack of routine health care. Check the record (assessment, service notes, progress notes, plan) to determine if any new health care needs have been identified and that the Service Coordinator has provided information for, offered choice of and monitored to make sure that the consumer has accessed health care to address those needs. Offering of choice must be documented in the service notes. If there are health care needs identified and the record clearly reflects the person/legal guardian's (if legal guardian is applicable) not to have a primary physician or if the record reflects the person has a primary physician and is satisfied with his/her physician, the record does not have to show that the Service Coordinator provided information for and offered choice of primary healthcare services/providers. When there is a healthcare need identified or there is a need for a primary physician or specialist, the person will be provided information for and offered a choice of primary healthcare/healthcare providers regardless of a physician's willingness to accept Medicaid or other specific funding. All persons must have a choice of physician/specialist for healthcare needs even if the Board / Provider contracts with a physician unless there are no other physicians in the area. Offering of choice or lack of healthcare providers in the area must be documented in the service notes.</p> <p>For residential or day program people, when healthcare needs are identified, if choice is offered of health care providers and the person continues to see the physician that all other people served are seeing, then the documentation of choice should be that the person chose that particular health care provider that everyone uses. Medical records/reports can serve as a form of assessment provided the Service Coordinator has addressed any further recommendations from those reports and by providing information (understanding of options of care and choice of providers) and monitoring access of healthcare services as a result of the recommendations. Check the record and the Plan to make sure that the Service Coordinator has assessed, identified, provided needed information, offered choice of and monitored for access of health care services.</p> <p>NOTE: Where there is no reasonable choice available due to the presence of only one qualifying physician within a reasonable distance, this item should be scored "Met" reflecting compliance provided that this is documented in the record.</p> <p>Source: Service Coordination Standards Supports CQL Basic Assurances - A3.</p>
G2-08	<p>Family Support funds were provided in accordance with SCDDSN Policy 734-01-DD.</p>	<p>Review the record to determine if the person received Family Support funds during the review period. If the person received Family Support funds, check the record for the following:</p> <ul style="list-style-type: none"> <li>• The person is eligible to receive Family Support as reflected in policy 734-01-DD</li> <li>• That the services are directed toward the person or his/her legal guardian because they have expenses that they need assistance with as a result of the person's disability</li> <li>• Services fall into one of the major allowable services categories as reflected in 734-01-DD</li> <li>• Approvals of requests fall into a priority area as reflected in 734-01-DD</li> <li>• If the need is not a major service category, documentation supports that the need is considered an "essential" need as defined by policy 734-01-DD</li> <li>• The person is not in the MR/RD or HASCI Waiver</li> <li>• Documentation supports that other public agencies and community resources were exhausted</li> <li>• If the person receives FSF that are not in accordance with policy, the record reflects that an exception to the policy was provided from DDSN.</li> </ul> <p>Source: 734-01-DD</p>

G2	SERVICE COORDINATION	GUIDANCE
G2-09	The Service Coordinator initiated any Family Support funds requests during the review period using the format outlined in policy 734-01-DD.	<p>Review the record to determine if the person or his/her legal guardian or Service Coordinator requested Family Support funds to meet an identified need and the proper format for requesting funds was completed appropriately by the Service Coordinator. If the Service Coordinator completed a request for Family Support during the review period, check the record for the following:</p> <ul style="list-style-type: none"> <li>• The Service Coordinator identified the person's/family's need for assistance during the assessment or planning process or as a result of the person's/family's individual situation changing during the year (check the service notes, Plan or any assessment tools)</li> <li>• The person's Plan, or service notes if the person is on Level II Service Coordination, and other documentation supplied included the need and justification for the service(s), including specific information to show how the amount was determined, and a description of services to be provided (review the Plan, service notes and any other information in the file)</li> <li>• Form # 350 "Request Form-Individual and Family Support Stipend" (or other approved form), which includes financial information, was completed by the Service Coordinator and signed by the person/guardian/parent</li> <li>• A copy of a current pay stub or other means of verifying both earned and unearned income was included for all adult household members (i.e. income tax forms). Also, check to make sure SSI was included in this information if received.</li> </ul> <p>Source: 734-01-DD</p>
G2-10	Service Coordinators will monitor and/or take appropriate actions to implement recommendations made in final written reports of critical incidents and abuse reports.	<p>Review the file to determine if a report of abuse or report of critical incident was made during the review period. If a report(s) were made, review the service notes to determine if the Service Coordinator monitored with the person and/or took appropriate actions (if the action/s are the Service Coordinator's responsibility (i.e., make referrals, plan changes, advocacy, etc.) to implement recommendations in the final written reports.</p> <p>Source: Service Coordination Standards</p>
G2-11	<p>a) At the time of annual planning, all people receiving Level I Service Coordination will be provided an estimate of the cost of services they receive.</p> <p>b) At the time of annual contact, all people receiving Level II Service Coordination will be informed that an estimate of the cost of services they receive (if any) is available upon request</p>	<p>a) Check record to see if there was documentation that an estimate of the cost of services was received and that the estimate is on file.</p> <p>b) Check the record to see if information is provided in the record that reflects notification occurred that an estimate of the cost of services is available.</p> <p>Source: Service Coordination Standards</p>
G2-12	The person/legal guardian (if legal guardian is applicable) will receive information on abuse and neglect annually.	<p>Check the record for documentation that information was provided to person/legal guardian. This may be found in service notes or as a form letter in the record. Information must define what abuse and neglect is and the different types of abuse. Also, information must include how to report abuse. (As part of the implementation of providing information to people beginning 7/1/08, a provider may choose to notify people as Support Plans come due. If this is the plan, then all files reviewed may not include this information until the person's Support Plan comes due/is completed).</p> <p>Source: Service Coordination Standards (update 4/2008)</p>

G2	SERVICE COORDINATION	GUIDANCE
		Supports CQL Organizing Principles- S4.
G2-13	Service Coordinators advocate for people as required	<p>Check the record (primarily documented in the service notes) to make sure Service Coordinators advocate for people by:</p> <ol style="list-style-type: none"> <li>1. offering choice prior to new services/interventions being started (in service notes)</li> <li>2. taking action when a need/s is/are identified and there is no service/intervention to address a need/s. This will occur by documentation in service notes to show that the Service Coordinator is attempting to find ways to meet a need. Needs can be addressed in numerous and creative ways to include notifying supervisors of needs where there is no service/intervention available so that agency collaboration/response can occur, referrals to community resources, etc.</li> <li>3. ensuring human and civil rights are maintained – the Service Coordinator will make sure all rights restrictions are reviewed by Human Rights. This does not mean the Service Coordinator will be present for ALL cases/situations taken to Human Rights but the SC must monitor to make sure all restrictions are reviewed.</li> <li>4. consulting/collaborating with service providers, other professionals funding sources, and/or community agencies/resources to address needs and/or ensure that necessary services are available and being provided.</li> </ol> <p>Source: Service Coordination Standards Supports CQL Basic Assurances - A6 and Organizing Principles- L1, L2, S2, S3, S4, S9, S10.</p>

G3	FACILITY BASED DAY SERVICES	GUIDANCE
G3-01	A comprehensive assessment that is appropriate for the service(s) authorized is completed within 30 days of admission / enrollment in the service and at least annually thereafter.	Source: Day Services Standards and Rehabilitation Supports Manual Supports CQL Organizing Principles- L3, S2, S3
G3-02	Within 30 days of admission/enrollment and at least annually thereafter a plan is completed.	Source: Day Services Standards and Rehabilitation Supports Manual Supports CQL Organizing Principles- L3, S2, S3
G3-03	The plan must include the supports/ interventions to be provided including care and supervision and skills training.	Source: Day Services Standards and Rehabilitation Supports Manual
G3-04	The supports / interventions within the plan must reflect the service(s) the person is authorized to receive.	<p>Supports within the Day Plan (Day Plan, Day Services Summary, Section 4) reflect Service Definitions:</p> <ul style="list-style-type: none"> <li>• Day Habilitation = Assistance with acquisition, retention, or improvement of self-help, socialization and adaptive skills. Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level. Examples: conceptual skills such as receptive and expressive language, money concepts; Social Skills such as interpersonal responsibility; follow rules; obey laws; Practical Skills such as personal activities of daily living such as eating, dressing, mobility and toileting. Also, instrumental activities of daily living such as taking medication, using the telephone, managing money, etc.</li> <li>• Prevocational Services = Preparing an individual for paid or unpaid employment, but are not job task oriented and are not directed at teaching job specific skills. Services include teaching concepts such as compliance, attendance, endurance, task completion, problem solving and safety. Prevocational Services may also include pre-employment skills / concepts such as self-advocacy, self-determination, rights, etc.</li> <li>• Rehabilitation Supports = Services to develop, retain or restore an optimal level of functioning in one or more of the following areas: Self-Care Skills; Community Living Skills; Psycho-Social Skills; and/or Medication Management / Symptom Reduction Skills. A person could receive 2 supports, which are consistent with 2 services. For example, staff follows a BSP which is consistent with Day Habilitation and the person is also learning to work faster/increase production (prevocational).</li> </ul> <p>Source: Day Services Standards and Rehabilitation Supports Manual</p>
G3-05	The supports/ interventions within the plan address needs identified by the assessment.	Source: Day Services Standards and Rehabilitation Supports Manual
G3-06	Once developed, the plan must be implemented.	Source: Day Services Standards and Rehabilitation Supports Manual Supports CQL Organizing Principles- S3

G3	FACILITY BASED DAY SERVICES	GUIDANCE
G3-07	The supports / interventions within the plan are implemented through functional activities.	Functional activities which are those that are frequently required in natural domestic, vocational, or community environments.  Source: 600-05-DD Supports CQL Organizing Principles- L3, S2, S3
G3-08	Data is collected for all interventions specified in the plan.	  Source: Day Services Standards and Rehabilitation Supports Manual
G3-09	Training Data is collected as specified by the current Day Service Data Recording Sheet.	Goals and objective progress data is collected and recorded daily on the Day Services Data Recording Sheet as specified by the current Day Plan.  Source: Day Services Standards and Rehabilitation Supports Manual
G3-10	A 6 month review must be completed for persons who receive rehabilitation supports.	Review the Day Service and Treatment Plan, Section 6; Six Month Review Summary <b>documentation</b> is complete. Six Month Review must be signed by the lead clinical staff and dated within the 6 months time frame from the development date of the Plan.  Source: Day Services Standards and Rehabilitation Supports Manual Supports CQL Organizing Principles- L3, S2, S3
<b>G3-11 R</b>	<b>A medical necessity statement must be obtained for persons who receive facility-based rehabilitation supports.</b>	<b>Each record must contain a Medical Necessity Statement that is signed by a Licensed Practitioner of the Healing Arts [e.g., physician, licensed psychologist, licensed master social worker, licensed registered nurse with a masters degree in nursing, licensed nurse practitioner, licensed doctor of Osteopath, licensed professional counselor (masters or doctoral level), or licensed family therapist (masters or doctoral level)], and is dated prior to the provision of Rehabilitation Support Services.</b>  <b>Source: Day Services Standards and Rehabilitation Supports Manual</b>
G3-12	The person's Plan is monitored by the Day Coordinator or Lead Clinical Coordinator (or designee) to insure timely amendments are made to supports identified within the Plan.	Amendments to the Plan must be made by the Day Coordinator or Lead Clinical Coordinator (or designee) immediately when the person: <ul style="list-style-type: none"> <li>• Meets a goal or objective</li> <li>• Is not benefiting from a specific intervention, service or support</li> <li>• Requests a change</li> <li>• New support needs are identified.</li> </ul> Source: Day Services Standards and Rehabilitation Supports Manual
G3-13	Training Progress is documented as specified by the current Day Service Monthly Progress Summary Note.	Progress data of goals and objectives stated on the Plan is recorded monthly on the Day Services Monthly Progress Summary Note.  Source: Day Services Standards and Rehabilitation Supports Manual Supports CQL Organizing Principles- S3

G4	INDIVIDUAL REHABILITATION SUPPORTS	GUIDANCE
G4-01	The Individual Rehabilitation Support Record contains a Medical Necessity Statement.	<p>Each record must contain a Medical Necessity Statement that is signed by a Licensed Practitioner of the Healing Arts (e.g. , physician, licensed psychologist, licensed master social worker, licensed registered nurse with a masters degree in nursing, licensed nurse practitioner, licensed doctor of Osteopath, licensed professional counselor (masters or doctoral level), or licensed family therapist (masters or doctoral level), and is dated prior to the provision of Individual Rehabilitation Support Services.</p> <p>Source: IRS Manual</p>
G4-02	Individual Rehabilitation Supports (IRS) goals and objectives are based on an assessed need and are developed to enhance the person's capacity for successful community living.	<p>Goals and objectives target one of the following areas :</p> <ul style="list-style-type: none"> <li>• Personal care: such as bathing, dressing, grooming, toileting, hygiene, dental care, and treating minor illnesses/wounds.</li> <li>• Cognitive/independent living skills: such as planning, organizing, and strategies to function as independently as possible on a daily basis; can include skills training in areas of memory, concentration, problem-solving, and self determination.</li> <li>• Medication management and symptom reduction: such as taking medications, purchasing/maintaining, storing, and identifying medications and conditions for which it is taken.</li> <li>• Health and nutrition: such as maintaining good health, preventing secondary conditions and following a prescribed diet.</li> <li>• Self-esteem: such as identify own values, needs, interests, and physical limitations, rights, self determination, self advocacy, citizenship.</li> <li>• Coping skills: such as managing stress, managing own behavior.</li> <li>• Personal responsibility and self-direction: such as setting personal or career goals, setting and maintaining a personal schedule, using an alarm.</li> <li>• Social Skills and positive interactions with others: such as communicating with other people, making appropriate comments and asking appropriate questions, maintaining personal space, staying focused on a topic/discussion.</li> <li>• Community living and peer relationships: such as money, financial, home care, safety, and contacting/associating with people in the community.</li> <li>• An assessment is available to indicate the areas of need and includes needs for which training goals and objectives have been implemented.</li> </ul> <p>Source: IRS Manual Supports CQL Organizing Principles- L3, S2, S3</p>
G4-03	Individual Rehabilitation Support objectives must be written to include identified methods, timeframes, and measurable indices of performance.	<p>The objective is stated in a manner which enables staff to clearly identify the target behavior when it is being displayed and how to determine successful achievement of the objective.</p> <p>The training program provides clear directions to any staff working with the service recipient on how to implement the training objective. Additionally, this methodology must specify any other information that would be important and would affect the training such as hearing loss, visual impairment, limited use of extremities, etc.</p> <p>The training program provides clear directions to any staff working with the service recipient about when the objective must be implemented.</p> <p>The training program is assigned a type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.</p> <p>The training program provides clear directions to any staff working with the service recipient about the type and frequency of data to be recorded. The data collection system is directly related to the outcome stated in the objective.</p> <p>Source: IRS Manual Supports CQL Organizing Principles- L3, S2, S3</p>
G4-04	Supports within the Plan	Service Definition:

G4	INDIVIDUAL REHABILITATION SUPPORTS	GUIDANCE
	correspond to the service definition.	<ul style="list-style-type: none"> <li>Rehabilitation Supports - Providing services to develop, retain or restore an optimal level of functioning in one or more of the following areas: Self-Care Skills; Community Living Skills; Psycho-Social Skills; and/or Medication Management/ Symptom Reduction Skills.</li> </ul>
G4-05	Individual Rehabilitation Supports record contains a Treatment Plan that is reviewed every 6 months and reformulated annually by the Lead Clinical Staff (LCS) or Life Skills Specialist (LSS).	<p>Annual Treatment Plan is conducted or updated by at least the 365th day after the last review and reviewed by the LCS or LSS within 6 months of the date of the Annual Treatment Plan (regardless of amendments to the treatment plan). During this review the LCS or LSS must evaluate the consumer's Treatment Plan to assess:</p> <ul style="list-style-type: none"> <li>The continued appropriateness and effectiveness of the goals/objectives identified within the treatment Plan in meeting the needs and goals of the person;</li> <li>Other issues pertinent to the functioning of the person;</li> <li>The specific need for the consumer to continue receiving Rehabilitation Support Services.</li> <li>Documentation of the review must be recorded on the Treatment Plan with a signature.</li> <li>The Treatment Plan must be signed by the person and Lead Clinical staff.</li> <li>The 6 Month Review must be signed the Lead Clinical staff and dated.</li> </ul> <p>Source: IRS Manual</p>
G4-06	Individual Rehabilitation Supports records contain Progress Summary Notes.	<p>The Progress Summary Note consists of the following 2 components:</p> <ul style="list-style-type: none"> <li>Progress Summary Note (Daily) (IRS Form 4B) - Daily documentation of progress must be recorded on this form.</li> <li>Progress Summary Note (Monthly Summary) (IRS Form 4C) - A narrative summary of the month's progress, lack of progress, activities of the person and staff, the involvement of the staff in the provision of service and the person's overall status of health and community living skills is recorded on the monthly summary.</li> </ul> <p>Source: IRS Manual Supports CQL Organizing Principles- L3, S2, S3</p>
G4-07	Individual Rehabilitation Supports Progress Summary Notes (Daily, RS form 4B) contain documentation of delivery of service(s).	<p>Review Progress Summary Notes (Daily, RS form 4B) for documentation of delivery of Rehabilitation Support services on the date service(s) were reported. Documentation from the Progress Summary Notes (Daily) should be consistent with monthly Progress Summary Notes and supports the services reported on the Report of Services Form(s) - RS Form 9 (2 of 2).</p> <p>Source: IRS Manual</p>
G4-08	Person's activities are consistent with the consumer's Treatment Plan.	<p>Documentation of the person's activities on the Progress Summary Notes is consistent with the goals and objectives on the person's Treatment Plan. The activities must support the achievement of the objective/goal.</p> <p>Source: IRS Manual Supports CQL Organizing Principles- S3</p>

G5	SUPPORTED EMPLOYMENT	GUIDANCE
G5-01	The record will contain current and valid assessments of vocational and self-advocacy skills with assessment results appropriately documented.	Review the record to ensure that it contains a copy of a current assessments with results appropriately documented. The plan has been developed and documentation of activities recorded. The assessments must be conducted within 35 business days of date of receipt of referral.  Source: Supported Employment Guidelines
G5-02	A Plan is located in the record.	Review the record to ensure that it contains a copy of the consumer's current and updated Plan. The Plan must be implemented within 45 business days of receipt of referral from Service Coordination.  Source: Supported Employment Guidelines
G5-03	The use of Person Centered Planning through a Consumer Driven Approach is evident in the record.	The record must reflect that the Consumer participated in decisions regarding his/her services and the consumer's abilities, interests and preferences have been taken into consideration in the development and implementation of the supported employment agreement.  Source: Supported Employment Guidelines Supports CQL Organizing Principles- L3, S2, S3
G5-04	Records will contain notations that show evidence of monitoring and evaluation of progress.	Documentation, monitoring and evaluating all activities of the Consumer is current and updated and is documented. Documentation included the date of the activity, the number of units for each activity and a detailed description of the activity.  Source: Supported Employment Guidelines Supports CQL Organizing Principles- S3
G5-05	The consumer's Plan documents needs and supports that are individualized, and current. The Job Development portion of the record is complete and present.	The consumer and the Employment Specialist will be accountable for the consumer's identified activities to obtain the employment goals. The Employment Specialist will provide needed and wanted supports to achieve the consumer's desired employment outcomes as evidenced in the consumer's Plan.  Source: Supported Employment Guidelines Supports CQL Organizing Principles- L3, S2, S3
G5-06	Job placement, wages and benefits are documented.	Verify record of job placement and ensure wages and benefits are documented.  Source: Supported Employment Guidelines
G5-07	The consumer is receiving individualized systemic on-the-job instruction and needed and wanted supports are being provided in a non-intrusive method.	Ensure the consumer is receiving individualized systemic on-the-job instruction and needed and wanted supports and interventions are being provided in a non-intrusive method.  Source: Supported Employment Guidelines Supports CQL Organizing Principles- S3
G5-08	Needs, preferences, and options are identified in long term support plans and the employment specialist has maintained contact monthly.	Identify needs, preferences, options and long-term support plans. The Employment Specialist must maintain contact (by phone or site visit) monthly for at least 6 months after the consumer has reached independence to insure job retention and stability.  Source: Supported Employment Guidelines Supports CQL Organizing Principles- S3
G5-09	An exit interview is conducted when a consumer is terminated from Services.	At the determined point that the customer becomes stabilized in his/her employment position and long term support needs have been identified or the customer is terminated voluntarily or involuntarily from services, an exit interview must be conducted. Events that lead to the termination of services, plans for future employment and/or a change in services must be addressed during this interview.  Source: Supported Employment Guidelines

G6	Residential Services	Guidance
G6-01	<p>The Residential Support Plan must include:</p> <ol style="list-style-type: none"> <li>The type and frequency of care to be provided</li> <li>The type and frequency of supervision to be provided</li> <li>The functional skills training to be provided</li> <li>Any other supports/interventions to be provided</li> <li>Description of how each intervention will be documented.</li> </ol>	<p>Score "Met" if,</p> <ul style="list-style-type: none"> <li>There is a residential support plan and</li> <li>The plan is within 365 calendar days old and</li> <li>The plan includes a description of care to be provided. <u>Care:</u> Assistance with or completion of tasks that cannot be completed by the person and about which the person is not being taught (including but not limited to medical/dental care, regulation of water temperature, fire evacuation needs, etc.)</li> <li>The plan includes a description of how the person is to be supervised throughout the day. <u>Supervision:</u> Oversight by another provided according to SCDDSN policy 510-01-DD Supervision of People Receiving Services and must be as specific and individualized as needed to allow freedom while assuring safety and welfare.</li> <li>The plan includes functional skills training to assist the person with acquiring, maintaining or improving skills related to activities of daily living, social and adaptive behavior necessary to function as independently as possible. <u>Skills training</u> outlined within the plan should focus on teaching the most useful skills/abilities for the person according to the person's priorities. Every consideration should be given to adaptations that could make the task easier/more quickly learned. <u>Functional:</u> Activities/skills/abilities that are frequently required in natural, domestic or community environments.</li> </ul> <p>Source: Residential Habilitation Standard 4.6 <b>Supports CQL Organizing Principles- L3, S2, S3</b></p>
G6-02	<p>A comprehensive functional assessment:</p> <ol style="list-style-type: none"> <li>Is completed prior to the development of the initial plan</li> <li>Is updated as needed to insure accuracy</li> </ol>	<p>Score "Met" if a comprehensive functional assessment has been done addressing the following areas:</p> <p>Self Care:</p> <ol style="list-style-type: none"> <li>Bowel/bladder care</li> <li>Bathing/grooming (including ability to regulate water temperature)</li> <li>Dressing</li> <li>Eating</li> <li>Ambulation/Mobility</li> <li>Need to use, maintain prosthetic/adaptive equipment.</li> </ol> <p>Personal Health:</p> <ol style="list-style-type: none"> <li>Need for professional medical care (how often, what care)</li> <li>Ability to treat self or identify the need to seek assistance</li> <li>Ability to administer own meds/treatments (routine, time limited, etc.)</li> <li>Ability to administer over the counter meds for acute illness</li> <li>Ability to seek assistance when needed.</li> </ol> <p>Self Preservation:</p> <ol style="list-style-type: none"> <li>Respond to emergency</li> <li>Practice routine safety measures</li> <li>Avoid hazards</li> <li>Manage (use/avoid) potentially harmful household substances</li> <li>Ability to regulate water temperature</li> </ol> <p>Self Supervision:</p> <ol style="list-style-type: none"> <li>Need for supervision during bathing, dining, sleeping, other times during the day</li> <li>Ability to manage own behavior</li> </ol> <p>Rights:</p> <ol style="list-style-type: none"> <li>Human – rights established by the United Nations that all people are entitled to by virtue of the fact that they are human. Ex. Life, liberty and security of person, right not to be subjected to torture, etc.</li> <li>Civil – rights guaranteed by law. Ex. Americans with Disabilities Act</li> <li>Constitutional – rights guaranteed by the Constitution of the United States. Ex., free speech, right to due process, etc.</li> </ol>

		<p>Personal finances/money: People are expected to manage their own money to the extent of their ability.</p> <p>Community Involvement:</p> <ul style="list-style-type: none"> <li>a) Extent of involvement</li> <li>b) Awareness of community activities</li> <li>c) Frequency</li> <li>d) Type</li> </ul> <p>Social network/family relationships</p> <ul style="list-style-type: none"> <li>a) Family and Friends</li> <li>b) Status of relationships</li> <li>c) Desired contact</li> <li>d) Support to re-establish/maintain contact</li> </ul> <p>AND the assessment supports skills training, care and supervision objectives identified within the person's plan.</p> <p>AND the assessment is current i.e. accurately reflects the skills/abilities of the person.</p> <p>Events that may trigger an assessment update may include, but not be limited to: completion of a training objective, failure to progress on a training objective, upcoming annual plan, major change in health/functioning status such as stroke, hospitalization, etc.</p> <p>The assessment does not have to be re-done annually. It is acceptable to review the assessment and indicate the date of review and the fact that the assessment remains current and valid. This notation must be signed or initialed by the staff that completed the review.</p> <p>Source: Residential Habilitation Standard RH 4.4</p> <p><b>Supports CQL Organizing Principles- S3</b></p>
G6-03	<p>The person's interests and life goals are identified with direct input from the person:</p> <ul style="list-style-type: none"> <li>A. Prior to the development of the Residential Support Plan</li> <li>B. As needed to insure information is current</li> </ul>	<p>Score "Met" if there is evidence that the person's interests and life goals are actively solicited.</p> <p>Actively solicited means that on an on-going basis, people are talked with about their interests and personal goals.</p> <p>For persons who do not communicate verbally, personal goals and interests are determined through observations and talking to others who know the person well.</p> <p>At a minimum, information regarding personal goals must be solicited prior to the development of the Residential Support Plan and at the time of the quarterly summary.</p> <p>AND Personal goals are addressed in the Residential Support Plan.</p> <p>Source: Residential Habilitation Standard RH 4.2</p> <p><b>Supports CQL Organizing Principles- L3, S2, S3</b></p>
G6-04	<p>Each intervention identified within the Plan corresponds to a personal goal or assessed need.</p>	<p>Score "Met" if there is a clear link between specific interventions and the person's life goals, personal assessment data and/or professional recommendations.</p> <p>Skills training should reflect the person's interests.</p> <p>Source: Residential Habilitation Standard RH 4.6</p> <p>Residential Support Plan Guidance</p> <p><b>Supports CQL Organizing Principles- S3</b></p>

G6	Residential Services	Guidance
G6-05	<p>Within 30 days of admission and every 365 days thereafter, a residential plan is developed:</p> <ol style="list-style-type: none"> <li>that supports the person to live the way he/she wants to live</li> <li>that reflects balance between self determination and health and safety</li> <li>that reflects the interventions to be applied.</li> </ol>	<p>Initial plan must be developed within 30 days of admission and every 365 days thereafter.</p> <p>The Plan must reflect the person's priorities and a balance between self determination and health and safety.</p> <p>Source: Residential Habilitation Standard RH 4.5 The document, "Balancing the Rights of Consumers to Choose with the Responsibility of Agencies to Protect" which is located on the extranet under Quality Assurance.</p> <p><b>Supports CQL Organizing Principles- L3, S2, S3</b></p>
G6-06	<p>The effectiveness of the residential plan is monitored and the plan is amended when:</p> <ol style="list-style-type: none"> <li>No progress is noted on an intervention</li> <li>A new intervention, strategy, training or support is identified; or</li> <li>The person is not satisfied with the intervention.</li> </ol>	<p>Data should be analyzed monthly to see that training has been completed as scheduled and data is collected as prescribed.</p> <p>Corrective action is taken and recorded when: The plan is not consistently implemented by staff; Inaccuracies are noted in the plan; there is no correlation between recorded data and observed individual performance; the health, safety and welfare of people is not maintained, when the person is not satisfied with the intervention, etc.</p> <p>As a general rule, if no progress has been noted for three (3) consecutive months with no reasonable justification for the lack of progress, the strategy must be amended, and if necessary, the Plan as well.</p> <p>Source: Residential Habilitation Standard 4.9 <b>Supports CQL Organizing Principles- S3</b></p>
G6-07	A quarterly report of the status of the interventions in the plan must be completed.	<p>Score "Met" if a summary of progress is done quarterly at a minimum. The provider may elect to do monthly progress notes. If monthly progress notes are done, quarterly reports are not required.</p> <p>Source: Residential Habilitation Standard 4.7</p>
G6-08	People receive training on rights and responsibilities	<p>Score "Met" if there is evidence that training on rights and responsibilities is occurring. Training may include but not be limited to:</p> <p>On-going exposure to information regarding rights (ex. Agency wide focus on right of the month, rights discussions during house meetings, involvement in focus groups organized around rights, etc. Formal training objectives on rights that are most important to the person (ex. How to vote.)</p> <p>Source: Residential Habilitation Standard RH 2.0 <b>Supports CQL Basic Assurances - A6 and Organizing Principles- L3, S2, S3</b></p>
G6-09	Personal freedoms are not restricted without due process.	<p>Personal freedoms include but are not limited to:</p> <ul style="list-style-type: none"> <li>Making a phone call in private.</li> <li>Entertaining family/visitors in a private area.</li> <li>Unopened mail.</li> <li>Food choices</li> <li>Free access to the environment in which they live.</li> <li>Possessing a key to their bedroom and home if they so desire.</li> </ul> <p><u>Due process</u> means human rights review of any restriction.</p> <p>The person must be offered the opportunity to attend the HRC meeting and have someone accompany them to assist in advocating for themselves, if they so desire. Verified by Service Notes.</p> <p>Source: Residential Habilitation Standard RH 2.0 535-02-DD Human Rights Committee <b>Supports CQL Basic Assurances - A7 and Organizing Principles- L3, S2, S3</b></p>

G6	Residential Services	Guidance
G6-10	<p>People's preferences / wishes / desires for how, where and with whom they live are learned from the person:</p> <ul style="list-style-type: none"> <li>A. Prior to entry into a residential setting; and</li> <li>B. Continuously</li> </ul>	<p>Score "Met" if the person's preferences are actively solicited on an on-going basis and results documented in service notes/ residential summary of progress.</p> <p>On-going basis means that at a minimum, on a quarterly basis, service notes/residential summary of progress, should contain documentation that the preferences/wishes/desires for how, where and with whom they live are learned from the person and that those preferences/wishes/desires are acted upon whenever possible within the resources of the person/provider.</p> <p>Source: Residential Habilitation Standard RH 1.2  <b>Supports CQL Organizing Principles- L2, L3, S2, S3, S9, S10</b></p>
G6-11	<p>People are supported to make decisions and exercise choices regarding their daily activities.</p>	<p>Score "Met" if there is evidence that people's schedules of activities are developed in consultation with them and according to their preferences, including but not limited to mealtime, bedtime, menu items, snack choices, restaurant choices, and community activities.</p> <p>AND major changes that affect the person are not made without consultation with them.</p> <p>Source: Residential Habilitation Standard RH 2.1 <b>Supports CQL Organizing Principles- L2, L3, S2, S3, S4, S8</b></p>
G6-12	<p>People are expected to manage their own funds to the extent of their capability.</p>	<p>People should manage their funds to the extent that they are capable. If assistance must be provided, provisions of 200-12-DD apply. The person must be actively involved in the development of their financial plan to include but not be limited to: planned purchases, weekly spending money, saving, etc.</p> <p>People should receive a regular accounting of their funds (amount, what it is spent for, where it is kept, how to access it, etc.)</p> <p>Source: Residential Habilitation Standard RH 2.0  200-12-DD Management of Funds for Individuals  Participating in Community Residential Programs  Supports CQL Basic Assurances A6, A10.</p>
G6-13	<p>People who receive services are trained on what constitutes abuse and how and to whom to report.</p>	<p>Score "Met" if there is evidence that training on abuse is occurring on an ongoing basis. On-going training means that information about abuse/neglect is incorporated into all aspects of the training program not a one-time, large group training experience. Training may occur at meetings within residences, "rap sessions", Self-advocates meetings, etc. as well as in formal training objectives.</p> <p>Source: Residential Habilitation Standard RH 2.2 534-02-DD Procedures for Preventing and Reporting Abuse, Neglect, or Exploitation of People Receiving Services from DDSN or a Contract Provider Agency.  <b>Supports CQL Basic Assurances A2, A6.</b></p>
G6-14	<p>People are supported to form and maintain a variety of connections, ties and involvements in the community</p>	<p>Look for evidence that people are supported to be involved in such activities as volunteering, joining clubs, groups, and/or organizations, and becoming a member of the church of their choice, etc.</p> <p>Source: Residential Habilitation Standard RH 3.0  <b>Supports CQL Organizing Principles- L3, L4, S2, S3, S10.</b></p>
G6-15	<p>People are supported and encouraged to participate and be involved in the life of the community.</p>	<p>Score "Met" if there is evidence that people are given information about opportunities for community participation i.e. people are made aware of community activities such as ballgames, concerts, shopping, dining out, going to parks, benefits, etc. and are encouraged to participate in activities that interest them.</p> <p>Source: Residential Habilitation Standard RH 3.0  <b>Supports CQL Organizing Principles- L3, L4, S2, S3, S10.</b></p>

G6	Residential Services	Guidance
G6-16	People are supported to maintain and enhance links with families, friends or other support networks.	<p>Score “Met” if Information about the person’s family, friends or other support networks is known and the status of the relationships is known.  AND the person is supported to maintain contact or to re-establish contact according to his/her wishes. If contact cannot be established or maintained due to circumstances beyond the provider’s control (ex. Family refuses contact) the person is supported to understand and to develop alternative relationships.</p> <p>Source: Residential Habilitation Standard RH 3.1 <b>Supports CQL Organizing Principles- L3, L4, S10.</b></p>
G6-17	People who attend school are supported as needed to enable them to benefit fully from their school experience.	<p>Score “Met” if there is evidence that the person’s support includes but is not limited to help with homework, assistance to participate in school activities and functions, working in conjunction with school personnel on issues, responding to correspondence from the school.  When recipient is a minor, an understanding regarding participation with the guardian must be reached.</p> <p>Source: Residential Habilitation Standard RH 4.8  <b>Supports CQL Organizing Principles- L4, L8.</b></p>
G6-18	People receive a health examination by a licensed Physician, Physician’s Assistant, or Certified Nurse Practitioner who determines the need for and frequency of medical care and there is documentation that the recommendations are being followed.	<p>Score “Met” if:</p> <ul style="list-style-type: none"> <li>the person has received an exam by a licensed physician, Physician’s Assistant or Certified Nurse Practitioner</li> <li>AND there is documentation that the plan of care is being followed</li> <li>AND the health care received is comparable to any person of the same age, group and sex. i.e. mammogram for females 40 and above, annual pap smears, prostate checks for males over 50, etc</li> <li>Health conditions such as dysphasia and GERD are ruled out before behaviors such as rumination, intentional vomiting, etc. are addressed behaviorally.</li> <li>People with specific health concerns, such as seizures, people who are prone to aspirate, etc. receive individualized care and follow-up.</li> </ul> <p>Note: If the person has refused medical care, documentation of this must be in the file.</p> <p>Source: Residential Habilitation Standard RH 5.0  <b>Supports CQL Basic Assurances - A3.</b></p>
G6-19	People receive a dental examination by a licensed dentist who determines the need for and frequency of dental care and there is documentation that the dentist’s recommendations are being carried out.	<p>Score “Met” if there is documentation that a dental exam has been done by a licensed dentist and there is evidence that the recommendations are being carried out.  Note: If the person has refused dental care, documentation of this must be in the file.</p> <p>Source: Residential Habilitation Standard RH 5.0  <b>Supports CQL Basic Assurances - A3.</b></p>
G6-20  {A3, L2, L3}	People actively participate in their health care decisions according to their skills and abilities.	<p>Score “Met” if there is evidence that to the extent capable, people:</p> <p>Choose their physician, dentist, optometrist, etc.  Make their own appointments  Are informed when appointments are made for them.  Are informed about the purpose for the appointment and/or follow up visit.  Are supported to ask questions of their medical care providers.  Receive information regarding medications they take and potential side effects  Treatments and alternatives are explained to them.</p> <p>Source: Residential Habilitation Standard RH 5.0  <b>Supports CQL Basic Assurances - A3.</b></p>

G6	Residential Services	Guidance
<p>G6-21</p> <p>{A3}</p>	<p>People are supported to develop/maintain a healthy lifestyle and to engage in wellness activities.</p>	<p>Score “Met” if there is evidence that people are supported to engage in wellness activities which may include, but not be limited to: smoking cessation programs, nutrition/ weight management and physical fitness activities through involvement in programs such as Steps To Your Health, YMCA membership, etc.</p> <p>Source; Residential Habilitation Standard RH 5.0</p> <p><b>Supports CQL Basic Assurances - A3.</b></p>

G7	HEALTH AND BEHAVIOR SUPPORT SERVICES	GUIDANCE
G7-01	Behavior(s) that pose a risk to the person, others, the environment, or that interfere with his/her ability to function in the environment are addressed.	<p>If behaviors that pose a risk to the person, others or the environment or that interfere with the person's ability to function in the environment are being displayed, the behaviors must be addressed. Review the Plan, service notes, progress notes, critical incident reports and other documentation to determine if the problem behaviors occurred. Review documentation to determine if the behaviors were identified and are being addressed. Behaviors may be considered to be addressed if their occurrence is acknowledged and there is a Plan for when the frequency of occurrence will warrant further intervention, steps are being taken to analyze and assess the behavior so that a strategy can be developed, informal strategies such as environmental changes, etc. are being tried, a BSP or guidelines are being implemented. Behaviors may also be considered addressed if there is evidence that an approved provider was sought (even if not found). More than one provider should be contacted before it can be determined that no provider is available.</p> <p>Source: 600-05-DD <b>Supports CQL Basic Assurances - A7.</b></p>
G7-02	As needed by the person, but at least quarterly, psychotropic medications and the BSP are reviewed by the consulting psychiatrist, behavior consultant, and support team.	<p>[Psychotropic Drug Reviews] Review BSP, any psychiatrist and behavior consultant notes, and documentation of support team meetings to determine if psychotropic medications and the effectiveness of the BSP are reviewed at least quarterly for: A. Desired responses; B. Adverse side-effects; and C. Gradual decrease in drug dosage and ultimate discontinuance of the drug(s) unless clinical evidence/data is documented that this is contraindicated.</p> <p>Source: 600.05-DD <b>Supports CQL Basic Assurances - A7.</b></p>
G7-03	The specific behaviors / psychiatric symptoms targeted for change by the use of the Psychotropic medication are clearly noted.	<p>Clearly noted by prescribing physician.</p> <p>Source: 600.05-DD <b>Supports CQL Basic Assurances - A7.</b></p>
G7-04	The Psychotropic Drug Review process provides for gradually diminishing medication dosages and ultimately discontinuing the drug unless clinical evidence to the contrary is present.	<p>Source: 600.55-DD <b>Supports CQL Basic Assurances - A7.</b></p>
G7-05	Consent for health care or restrictive interventions is obtained in accordance with 535.07-DD.	<p>Review for documentation that procedures or restriction was discussed with the person and surrogate, if required, before presentation to the HRC and person was informed of his/her right to refuse and appeal.</p> <p>Source: 535.07-DD <b>Supports CQL Basic Assurances - A7.</b></p>
G7-06	When prescribed anti-psychotic medication or other medication(s) associated with Tardive Dyskinesia, monitoring is conducted pursuant to 603-01-DD.	<p>Source: 603-01-DD <b>Supports CQL Basic Assurances - A3, A7.</b></p>
G7-07	Recommendations made following GERD / Dysphasia screening and review have been implemented	<p>(Names will be provided by SCDDSN)</p> <p>Source: Residential Habilitation Standards (RH.5) <b>Supports CQL Basic Assurances - A3.</b></p>

G8	HASCI WAIVER	GUIDANCE
G8-01 R	The Plan documents Waiver supports including service name, the amount, frequency and duration of each service, and provider type.	<p>For each Waiver service received by the person, the Support Plan/Plan changes/revisions must document the need for the service, the correct Waiver service name, the amount, frequency and duration of the service, and the provider type. The funding source for Waiver Services must note HASCI Waiver. For HASCI Waiver participants, the Support Plan must reflect the exact HASCI Waiver service name or an acceptable substitute.</p> <p>If the Waiver participant receives Attendant Care/Personal Assistance Services, the frequency and intensity of Nurse Supervision of Attendant Care must be noted in the Service Coordinator's Responsibilities section of section D (Needs and Services/Interventions) of the Plan. If the Waiver participant is able to self-direct his attendant care services, certification is required in writing by a licensed nurse. If the Waiver participant receives UAP attendant care services, a self-directed option, a statement noting the participant or his/her responsible party directs the care/attendant care services must be noted in the Service Coordinator's Responsibilities Section of the Plan. For UAP attendant care services, supervision of the attendant may be performed directly by the Waiver participant or a responsible party that he/she chooses. The licensed nurse with the UAP attendant care services will certify by direct observation if the Waiver participant <u>or</u> the responsible party is able to direct the services.</p> <p>The following are HASCI Waiver services and the Support Plan must reflect the exact HASCI Waiver service name or an acceptable substitute and the provider type as listed on the table below:</p> <p><u>Waiver Service Name</u>  Respite Care      Respite      Respite Care Services</p> <p><u>Provider Type</u>  Local DSN Board/contracted providers  Nursing Home  Hospitals  Residential Care Facilities  Medicaid Certified ICF/MR facility  Foster Home  Respite provider agencies</p> <p><u>Waiver Service Name</u>  Medical Supplies, Equipment and Assistive Technology      Medical Supplies      Medical Equipment      Assistive Technology</p> <p><u>Provider Type</u>  Durable Medical Equipment providers  Independent Rehabilitation Engineering Technologists, assistive technology practitioners and assistive technology suppliers certified by the Rehabilitation Engineering Society of North America (Individuals and Agencies)  Independent Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME) (Individuals and Agencies)  DSN Board/contracted providers  Licensed Occupational or Physical Therapists (Individual and Agencies)  Vendors with a retail or wholesale business license (Individuals and Agencies)  Technicians or professionals certified in the installation and repair of manufacturer's equipment (Individuals and Agencies)</p> <p><u>Waiver Service Name</u></p>

G8	HASCI WAIVER	GUIDANCE
		<p> <b>Personal Emergency Response Systems</b>  <b>PERS</b>  <b>Personal Emergency Response System</b>  <u>Provider Type</u>  DSN Boards/contracted providers  Personal Emergency Response providers </p> <p> <u>Waiver Service Name</u>  <b>Medicaid Waiver Nursing</b>  Nursing Services  Nursing  <u>Provider Type</u>  Nurses (Individuals and Agencies) </p> <p> <u>Waiver Service Name</u>  <b>Psychological Services</b>  Psychological  <u>Provider Type</u>  Rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)  Psychological service providers approved by SCDDSN/SCDHHS (Individuals and Agencies)  DSN Boards/contracted providers  Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC) (Individuals and Agencies) </p> <p> <u>Waiver Service Name</u>  <b>Speech, Hearing and Language Services</b>  Speech Services  Speech Therapy  <u>Provider Type</u>  Audiologist (Individuals and Agencies)  Speech Pathologists (Individuals and Agencies)  Speech Therapists (Individuals and Agencies) </p> <p> <u>Waiver Service Name</u>  <b>Physical Therapy Services</b>  Physical Therapy  PT  <u>Provider Type</u>  Physical Therapists (Individuals and Agencies) </p> <p> <u>Waiver Service Name</u>  <b>Occupational Therapy Services</b>  Occupational Therapy  OT  <u>Provider Type</u>  Occupational Therapist (Individuals and Agencies) </p> <p> <u>Waiver Service Name</u>  <b>Prescribed Drugs</b>  Drugs  <u>Provider Type</u>  Pharmacists (Individuals and Agencies) </p> <p> <u>Waiver Service Name</u>  <b>Attendant Care/Personal Assistance Services</b>  Attendant Care/Personal Assistance  Attc/PAS </p>

G8	HASCI WAIVER	GUIDANCE
		<p> <b>Attendant Care Services</b>  <b>Attendant Care</b>  <b>Attc</b>  <b>Personal Assistance</b>  <b>Personal Assistance Services</b> </p> <p> <u><b>Provider Type</b></u>  <b>Attendant care provider agencies</b>  <b>DSN Board/contracted providers</b>  <b>Independent attendant care providers</b> </p> <p> <u><b>Waiver Service Name</b></u>  <b>Residential Habilitation</b>  <b>Residential Hab.</b>  <b>Residential</b> </p> <p> <u><b>Provider Type</b></u>  <b>DSN Board/contracted providers</b>  <b>In unlicensed settings: Rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)</b>  <b>In unlicensed settings: Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC) (Individuals and Agencies)</b> </p> <p> <u><b>Waiver Service Name</b></u>  <b>Day Habilitation</b>  <b>Day Hab</b> </p> <p> <u><b>Provider Type</b></u>  <b>DSN Board/contracted providers</b>  <b>In unlicensed settings: Rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)</b>  <b>In unlicensed settings: Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC) (Individuals and agencies)</b> </p> <p> <u><b>Waiver Service Name</b></u>  <b>Prevocational Services</b>  <b>Prevocational</b>  <b>PreVoc</b>  <b>Prevocation</b> </p> <p> <u><b>Provider Type</b></u>  <b>DSN Board/contracted providers</b>  <b>In unlicensed settings: Rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)</b>  <b>In unlicensed settings: Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC) (Individuals and Agencies)</b> </p> <p> <u><b>Waiver Service Name</b></u>  <b>Supported Employment Services</b>  <b>Supported Employment</b> </p> <p> <u><b>Provider Type</b></u>  <b>DSN Board/contracted providers</b>  <b>In unlicensed settings: Rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)</b>  <b>In unlicensed settings: Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC) (Individuals and Agencies)</b> </p> <p> <u><b>Waiver Service Name</b></u>  <b>Behavioral Support Services</b>  <b>Behavioral Support</b> </p> <p> <u><b>Provider Type</b></u> </p>

G8	HASCI WAIVER	GUIDANCE
		<p>DSN Boards/contracted providers  Rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)  Behavior support providers approved by SCDDSN/SCDHHS (Individuals and Agencies)  Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC) (Individuals and Agencies)</p> <p><u>Waiver Service Name</u>  Private Vehicle Modifications  Vehicle Modifications  Vehicle Mods.</p> <p><u>Provider Type</u>  DME providers  DSN Board/contracted providers  Occupational Therapists or Physical Therapists (Individuals and Agencies)  Rehabilitation Engineering Technologists, Assistive Technology Practitioners, and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA) (Individuals and Agencies)  Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME) (Individuals and Agencies)  Vendor with a retail or wholesale business license contracted to provide services (Individuals and Agencies)  Technicians or professionals who are certified in the installation and repair of manufacturer's equipment (Individuals and Agencies)</p> <p><u>Waiver Service Name</u>  Environmental Modifications  Environmental Mods.  Enviro. Mods</p> <p><u>Provider Type</u>  Licensed Contractor (Individuals and Agencies)  DSN Board/contracted providers  Durable Medical Equipment Providers  Licensed Occupational and Physical Therapists (Individuals and Agencies)  Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA) (Individuals and Agencies)  Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME). (Individuals and Agencies)  Vendors with a retail or wholesale business license contracted to provide services (Individuals and Agencies)  Technicians or professional certified in the installation and repair of Manufacturers equipment (Individuals and Agencies)</p> <p><u>Waiver Service Name</u>  Health Education for Consumer-Directed Care  Health Education</p> <p><u>Provider Type</u>  DSN Board/contracted providers  Rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF) that employ/contract with registered Nurses</p> <p><u>Waiver Service Name</u>  Peer Guidance for Consumer-Directed Care  Peer Guidance</p> <p><u>Provider Type</u>  DSN Board/contracted providers</p>

G8	HASCI WAIVER	GUIDANCE
		<p>Rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)  Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC) (Individuals and Agencies)</p> <p>Source: HASCI Waiver Manual</p>
G8-02	The Freedom of Choice Form is present.	<p>Review the record to ensure that the Freedom of Choice form is present in the record. The form must be "checked" to indicate choice of Waiver services in the community over institutionalization and signed by the Waiver participant or his/her legal guardian. If the Waiver participant is over age 18 and not adjudicated incompetent but is physically unable to sign the form, the form and the contact notes should indicate why signed choice was not obtained. If the person has reached the age of majority since Waiver enrollment and has not been adjudicated incompetent, the Waiver participant must either date and sign a new Freedom of Choice form or sign and date the original Freedom of Choice form documenting choice of Waiver services in the community over institutionalization. This should be completed within 30 days of their 18th birthday.</p> <p>Source: HASCI Waiver Manual</p>
G8-03	The Freedom of Choice form is signed prior to Waiver enrollment.	<p>Review Freedom of Choice form and Waiver enrollment date.</p> <p>Source: HASCI Waiver Manual</p>
G8-04	The Initial Level of Care is present.	<p>Review the initial LOC determination to determine if it was completed prior to or on the date of Waiver enrollment.  For ICF/MR Level of care, the initial Level of Care date is the "effective date" on the Certification Letter (ICF/MR Level of Care).  For NF Level of Care, the initial Level of Care date is the date on the CLTC transmittal form (NF Level of Care, HASCI Form 7).  NOTE: A person must be enrolled in the Waiver within 30 days of the initial Level of Care (LOC) determination.  NOTE: If the person is enrolled in the Waiver within 30 days of the initial LOC determination the LOC effective date is valid for 365 days from the initial LOC date.</p> <p>Source: HASCI Waiver Manual</p>
G8-05 R	The most current Recertification is dated within 365 days of the last recertification.	<p>If not met, document review period dates and date range out of compliance*  Review the most recent and previous Level of Care evaluations to ensure that recertification occurred within 365 days. The date the ICF/MR Level of Care Re-evaluation is completed, is the effective date. Therefore, if the ICF/MR Level of Care Re-evaluation was completed on July 3, 2004 the effective date would be 7/3/04 and expiration date of 7/2/05.  For NF Level of Care, the recertification date is the date located on the HASCI Form 6. For Nursing Facility Level of Care, contact notes must reflect that the reevaluation occurred on a home visit with the Waiver participant and the re-evaluation was staffed with the Service Coordination Supervisor or other responsible party within 2 working days of the home visit as verified by initial and date of the supervisor on DHHS Form 1718. The staffing date is the NF LOC date.</p> <p>Source: HASCI Waiver Manual</p>

G8	HASCI WAIVER	GUIDANCE
G8-06	The current Level of Care is supported by the current Plan and supporting assessments indicated on the LOC determination.	<p>Review the most current LOC determination (either a Nursing Facility Level of Care or an ICF/MR Level of Care completed) and compare it to information in the current Plan and other assessments referenced as sources for the LOC evaluation to determine if documentation supports the current Level of Care assessment. If the ICF/MR Level of Care is completed, the supporting assessments used to make the determination will be listed on the ICF/MR LOC determination and summarized in the Plan. If the Nursing Facility Level of Care is completed, the results of the determination will be summarized in the Plan.</p> <p>Source: HASCI Waiver Manual</p>
G8-07	If a person refuses a Waiver service(s), the risks associated with refusing the service(s) were addressed.	<p>Review contact notes and other record documentation along with all the Support Plans/Plan changes or revisions completed during the review period to determine if a person participating in the HASCI Waiver refused a Waiver service. If a service was refused, review record to locate documentation that the risks associated with refusing the service were addressed.</p> <p>Source: HASCI Waiver Manual</p>
G8-08	Records verify that evaluations/reevaluations were completed in accordance with procedures specified in the approved Waiver.	<p>Review ICF/MR Level of Care or the Nursing Facility Level of Care in the record. For ICF/MR Level of Care, initial evaluations are requested from SCDDSN's Consumer Assessment Team. The Service Coordinator must submit a packet of information to the team to determine LOC. Re-evaluations are completed by Service Coordinators for all persons except for those persons whose eligibility determination is "time-limited", "At Risk" or "High Risk". The Consumer Assessment Team must complete these re-evaluations. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid.</p> <p>For ICF/MR Level of Care Re-evaluations, the date the Level of Care Re-evaluation is completed, is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2004 the effective date would be 7/3/04 and expiration date of 7/2/05.</p> <p>For Nursing Facility (NF) Level of Care, SCDHHS Community Long Term Care (CLTC) conducts initial evaluations. The Service Coordinator is responsible for obtaining consent from the potential Waiver participant and forwarding the consent and transmittal request to CLTC.</p> <p>DDSN Service Coordination staff completes NF Level of Care re-evaluations. For NF Level of Care re-evaluations, contact notes must reflect that the reevaluation occurred on a home visit with the Waiver participant and the reevaluation was staffed with the Service Coordination Supervisor or other responsible party within 2 working days of the home visit as verified by initial and date of the supervisor on DHHS Form 1718 (NF/LOC document). The staffing date is the NF LOC date.</p>
G8-09	If the person was dis-enrolled / terminated from the HASCI Waiver, the Termination (HASCI Form 8) was completed within 2 working days of the dis-enrollment date.	<p>Review the contact notes, the Support Plan, Plan changes/revisions and Termination form to ensure that the Service Coordinator completed the form within 2 working days of notification that the Waiver participant needed to be dis-enrolled.</p> <p>Source: HASCI Waiver Manual</p>
G8-10	Documentation is present verifying that a choice of providers was offered to the person or his/her legal guardian for each HASCI Waiver service.	<p>Review the contact notes and the person's Support Plan, Plan changes/revisions to determine if the person or his/her legal guardian was given a choice of provider of service each time a service need was identified/authorized.</p> <p>Source: HASCI Waiver Manual</p>

<b>G8</b>	<b>HASCI WAIVER</b>	<b>GUIDANCE</b>
G8-11	The Acknowledgement of Choice and Appeal Rights is completed prior to Waiver enrollment and with the annual Plan.	Review the record to ensure that the Acknowledgement of Choice and Appeal Rights (HASCI Form 19) is present. Review signature dates on the forms to ensure that one was completed prior to Waiver enrollment and the other was completed with the annual Plan.  Source: HASCI Waiver Manual
G8-12	The Acknowledgement of Rights & Responsibilities is present.	Review the record to ensure that the Acknowledgement of Rights and Responsibilities (HASCI Form 20) is present. This must be completed "one-time" at the Plan meeting. For new Waiver participants it must be completed <u>prior to Waiver enrollment</u> . It is not required annually. Persons will not have this form on record prior to December 2004 Score "Met" in this case.  Source: HASCI Waiver Manual
G8-13	Waiver services are provided according to provisions in the service definitions in the Waiver document.	Review Service definitions in the HASCI Waiver document for each service that the person is receiving. Review the person's Support Plan, Plan changes/revisions and contact notes to ensure that services are being provided according to the definitions.  Source: HASCI Waiver Manual
<b>G8-14 R</b>	<b>If Nursing Services are provided, an order from the physician is present and coordinates with the Authorization of Services Form (HASCI Form 12-D).</b>	<b>Review record to ensure that a Physician's Order for Nursing Services (Form 15) is available and is consistent with the amount and type of Nursing Services authorized for the person.</b>  Source: HASCI Waiver Manual
<b>G8-15 R</b>	<b>Evidence that services are not available under the VR program is present if individual receives Supported Employment or Prevocational services.</b>	<b>Review the record to determine if the individual is receiving Supported Employment or Prevocational services through the HASCI Waiver. If either service is received, review record to locate documentation supporting that this service is not available under a VR program for the person.</b>  Source: HASCI Waiver Manual
G8-16	HASCI Waiver services are received at least every 30 days.	Review services notes, the person's Support Plan, and Plan changes/revisions to ensure that the person has received or is receiving at least one Waiver service each month during the review period. A service must be received during each calendar month. If at least one service was not received each month, the person should have been dis-enrolled from the Waiver. For example, if a Waiver participant receives a Waiver service on March 17th and receives no other Waiver services before April 30th, then the Waiver participant would be dis-enrolled from the Waiver.  Source: HASCI Waiver Manual
G8-17	Service needs and personal goals outside the scope of Waiver services are identified in the Support Plans and addressed.	Review the Support Plan, Plan changes/revisions, contact notes, and other documentation in the record to ensure that the Service Coordinator has identified and addressed all service needs and personal goals for the person, regardless of the funding source.  Source: HASCI Waiver Manual
G8-18	Authorization forms are completed for services, as required, prior to service provision.	Authorization for Services forms are present and note a "start date" for services that should be the same or after the date of the Service Coordinator's signature. Authorization forms are required for all services except Prescribed Drugs.  Source: HASCI Waiver Manual

<b>G8</b>	<b>HASCI WAIVER</b>	<b>GUIDANCE</b>
G8-19	The established Waiver documentation index is followed.	Review the Waiver information in the record and compare it to the established HASCI Waiver documentation index.  Source: HASCI Waiver Manual
G8-20	Contact notes reflect Monitorship within 2 weeks of the start date of an ongoing service or provider change and include the usefulness, effectiveness, frequency, duration and the person or his / her legal guardian's satisfaction with the service.	Review contact notes, the Support Plan, Plan changes/revisions and service authorizations to determine if the person began receiving a new ongoing service and/or the person changed providers of a previously received ongoing service. If so, review contact notes, the Support Plan, Plan changes/revisions and other documentation in the record to determine if service or provider change was monitored within 2 weeks and documentation regarding the usefulness, effectiveness, frequency, duration and the person's or his/her legal guardian's satisfaction with the service is present.  Source: HASCI Waiver Manual
G8-21	Contact notes reflect Monitorship as often as needed but at least quarterly with the person or his/her legal guardian and includes a statement of the usefulness and effectiveness of all ongoing Waiver services and justification for continued need.	Review contact notes, the Support Plan, Plan changes/revisions and other documentation in the record to determine if the person or his/her legal guardian is contacted at least quarterly to monitor all Waiver services, including assessment of service provision and justification of continued need. At a minimum, the Service Coordinator will provide quarterly contact with the person or his/her legal guardian and review all Waiver service needs on the Support Plan. The Support Plan, Plan changes/revisions must document the Waiver service need or the continued need for a specific Waiver service.  Source: HASCI Waiver Manual
G8-22	One-Time Services: contact notes reflect contact with the person or his/her legal guardian within 2 weeks of the service and reflect that the service was received.	Review contact notes, the Support Plan, Plan changes/revisions and service authorizations to determine if the person or his/her legal guardian received any one-time services during the review period. If so, review the contact notes to determine if the service was monitored within 2 weeks to determine if the person received the service and provides a statement of usefulness, effectiveness and the person's satisfaction with the service.  Source: HASCI Waiver Manual
G8-23	Contact notes reflect an on-site visit during the construction phase for Environmental Modifications and within 2 weeks of completion.	Review contact notes, the Support Plan, Plan changes/revisions and service authorizations to determine if an environmental modification was completed during the review period. If so, review the contact notes to determine if the modification was seen by the Service Coordinator during both the construction phase and within 2 weeks of the completion date. Also review documentation to ensure support of the usefulness and effectiveness of the service along with the person's or his/her legal guardian's satisfaction with the service.  Source: HASCI Waiver Manual
G8-24	Contact notes reflect an on-site visit for Private Vehicle Modifications within 2 weeks of completion.	Review contact notes, the Support Plan, Plan changes/revisions and service authorizations to determine if a Private Vehicle Modification was completed during the review period. If so, review the contact notes to determine if the modification was seen by the Service Coordinator within 2 weeks of the completion date and documentation is available to support the usefulness, effectiveness, and benefit of the service along with the person's or his/her legal guardian's satisfaction with the service.  Source: HASCI Waiver Manual

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G8-25	For any one-time service that costs \$1500.00 or more, the Service Coordinator has made an on-site visit to observe the item and to document the item's usefulness and effectiveness.	<p>Review contact notes, the Support Plan, Plan changes/revisions and service authorizations to determine if any one-time service costing over \$1500.00 was provided during the review period. If so, review the contact notes to determine if the item was monitored on-site by the Service Coordinator and documentation is available to support the usefulness, effectiveness, and benefit of the service along with the person's or his/her legal guardian's satisfaction with the service.</p> <p>Source: HASCI Waiver Manual</p>
G8-26	Waiver Tracking System is consistent with records regarding services and the Plan includes and justifies the need for all HASCI Waiver services.	<p>Review the Waiver services listed in the Support Plan and Plan changes/revisions and compare them with the services listed on the Waiver tracking system. Also review the service authorizations and Medicaid Paid Claims to ensure that all Wavier Services are included and supported in the person's Plan.</p> <p>Source: HASCI Waiver Manual</p>
G8-27	The Person / Legal Guardian was notified in writing regarding any denial, termination, reduction, or suspension of Waiver services with accompanying appeals information.	<p>Review contact notes to determine if during the review period any Waiver services were reduced, suspended, terminated, or denied. If this is noted, then review the contact notes to determine if the person/legal guardian was notified in writing regarding the denial, suspension, termination or reduction of the service and provided with the appropriate appeals process.</p> <p>Source: HASCI Waiver Manual</p>
G8-28	For HASCI Waiver funded services provided by the Board (also called Board-based services), documentation is available to show the service was provided on the date the service was reported.	<p><u>Behavioral Support Services or Behavioral Support; Psychological Services or Psychological; Health Education for Consumer-Directed Care or Health Education; Peer Guidance for Consumer-Directed Care or Peer Guidance:</u> look for a copy of the license, certificate or Service Note that shows the provider is licensed or certified/trained. "Individual Summary of Caregiver Services Provided: reflects the amount of services provided. The Support Plan reflects the need for the service. Review the progress notes/comments of the provider of the service to ensure services are being provided as authorized. Data/documentation is available to show that needed services/interventions were provided at each visit. <u>Environmental modifications, Environmental Mods., or Enviro Mods.; Private Vehicle Modifications, Vehicle Modifications or Vehicle Mods.:</u> A copy of an invoice for the work with person's name and notation that the work is complete. NOTE: Not needed if direct billed. - The Plan must reflect the need for the modification and general description of the work to be completed. For Environmental Modifications, a licensed contractor must be used. Look for the license number issued by the SC Labor Licensing and Regulation (SCLLR). NOTE: An automatic door system or grab bars may be installed by a licensed contractor or a vendor with a retail or wholesale business license contracted to provide the service(s); for ex., a Durable Medical Equipment vendor. NOTE: All adaptations/modifications to the home that require building any type for example, using hammer and nails must be done by contractors that are licensed by the State of South Carolina through the SC Department of Labor, Licensing and Regulation, Contractor's Licensing Board. For Private Vehicle Modifications, the technician or professional must be trained in the installation and repair of manufacturer's equipment. Look for a copy of the certificate or Service Note that shows the technician reports that he/she has been trained/certified. <u>Personal Emergency Response Systems, Personal Emergency Response System, or PERS; Medical Supplies, Equipment and Assistive Technology, Medical Supplies, Medical Equipment or Assistive Technology:</u> look for a copy of an invoice for the system, the medical supplies or piece of equipment and notation that the system, medical supplies or equipment was received. <u>Attendant Care/Personal Assistance Services, Attc/PAS, Attendant Care Services, Attendant Care, Attc, Personal Assistance or Personal Assistance Services; Medicaid Waiver Nursing Services, Nursing Services or Nursing:</u> look for a copy of the Daily Log or Time Sheet (documentation) by the attendant (for attendant care services) or nurse (from nursing services) that is available to show that the services were provided as authorized. The Support Plan must justify the need for assistance with activities of daily living and personal care for attendant care services. For nursing services, the Support Plan must justify the need for the services as ordered by the physician.</p> <p>Source: HASCI Waiver Manual</p>

G8	HASCI WAIVER	GUIDANCE
G8-29	Documentation is present verifying that a provider is being actively sought when a provider is unavailable for any Waiver Service.	<p>Review the contact notes and the person's Plan to determine if the Service Coordinator is actively seeking a provider of a Waiver service when a provider has not been found to provide the service. NOTE: The Service Coordinator must contact the Waiver participant at least quarterly if the Waiver participant does not have a provider available for any Waiver service and assist in locating a chosen provider of services.</p> <p>Source: HASCI Waiver Manual</p>
G8-30	Nurse supervisory reports are present for attendant care services and the Support Plan includes the need, frequency and intensity of the supervision.	<p>Review the Support Plan to assure it includes the need for supervision or a statement that the person or responsible party is able to direct his/her care (this information will be included in the Service Coordinator's Responsibilities section of the Support Plan (Section D of the Support Plan) Please Note: If the new Support Plan was not used you must review the Waiver Services Summary Page of the Plan to assure that it includes the frequency and intensity of the nurse supervision of attendant care services. Review nurse (LPN or RN licensed to practice in the state) supervisory progress reports. Nurse supervisory reports must be received and reviewed by the Service Coordinator. Nurse supervisory reports are required from the nursing provider at least every 120 days unless there is a statement that the person or responsible party is able to direct his/her own care. Look for a copy of the nurse's license in the file or review contact notes documenting the license # of the nurse. NOTE: Nursing providers may complete supervisory reports every 90 days (depends on the provider), however, at least every 120 days is required. NOTE: Nurse supervisory reports are not required for a consumer receiving UAP (University Affiliated Project) Attendant Care Services.</p> <p>A person receiving UAP Attendant Care Services must be able to self-direct his/her own care or designate a responsible party (RP) that is able to direct the person's care. The Waiver Services Summary Page of the Plan or the Support Plan does not need to include the frequency and intensity of nurse supervision for UAP Attendant Care Services. A statement may be included in the comments section of the Waiver Services Summary Page or the Support Plan. NOTE: Supervision may be furnished directly by the person or responsible party when the individual or responsible party has been trained to perform this function and when the safety and efficacy of person-provided supervision has been certified in writing by a registered nurse (RN) or otherwise provided by State law. This certification must be based on direct observation of the person/responsible party and the specific attendant care/personal assistance provider during the actual provision of care. <b>Documentation of this certification must be maintained in the person's file and will be documented in the Plan.</b></p> <p>Source: HASCI Waiver Manual</p>
G8-31	Documentation is present verifying that the Attendant Care Daily Logs for a person receiving UAP Attendant Care Services are present in the record and received at least monthly by the Service Coordinator.	<p>Review the contact notes, the person's Support Plan, Plan changes/revisions and any other record documentation to ensure that the Service Coordinator has received a copy of the Attendant Care Daily Logs at least <u>monthly</u> from the UAP attendant.</p> <p>Source: HASCI Waiver Manual</p>

G9	MR/RD Waiver	Guidance
G9-01	The Plan clearly includes and justifies the need for all MR/RD Waiver services received.	<p>Review the Plan, service authorizations to ensure that all MR/RD Waiver service are included and supported by assessed need in the person's Plan. Services should be identified and provided according to MR/RD Waiver service definitions.</p> <p>Source: MR/RD Waiver Manual</p>
G9-02 R	The plan documents MR/RD Waiver supports including service name, frequency, amount, duration and provider type.	<p>For each waiver service received by the person, the plan must document the need for the service, the correct waiver service name/ acceptable substitute as listed below, the amount, frequency and duration of the service and the provider type (refer to the MR/RD Waiver Document page 16 and 17 for a list of provider types). A Waiver Services summary page must be present with the required information included. For all plans completed after July 1, 2007 the amount, frequency, duration and provider type will be listed on the needs/intervention pages of the Support Plan. The correct/acceptable service name must be used throughout the plan.</p> <p> <b>Adult Attendant Care Services</b>  <b>Attendant Care Services</b>  <b>Attendant Care</b>  <b>Adult Companion Services</b>  <b>Adult Companion</b>  <b>Companion</b>  <b>Adult Day Health Care Services</b>  <b>Adult Day Health</b>  <b>ADHC</b>  <b>Adult Day Health Care- Nursing Services</b>  <b>ADHC-Nursing</b>  <b>Adult Day Health Care-Transportation Services</b>  <b>ADHC-Transportation</b>  <b>Adult Dental Services</b>  <b>Adult Dental</b>  <b>Dental Services</b>  <b>Dental</b>  <b>Adult Vision Services</b>  <b>Adult Vision</b>  <b>Vision Services</b>  <b>Vision Care</b>  <b>Vision</b>  <b>Audiology Services</b>  <b>Audiology</b>  <b>Audiological Services</b>  <b>Behavior Support Services</b>  <b>Behavior Support</b>  <b>Day Habilitation</b>  <b>Day Hab.</b>  <b>Environmental Modifications</b>  <b>Environmental Mods.</b>  <b>Enviro. Mods.</b>  <b>Nursing Services</b>  <b>Nursing</b>  <b>Occupational Therapy Services</b>  <b>Occupational Therapy</b>  <b>OT</b>  <b>Personal Care Services I or 1</b>  <b>Personal Care I or 1</b>  <b>Personal Care Level I or 1</b>  <b>PCI or 1</b>  <b>Personal care service II or 2</b>  <b>Personal Care II or 2</b>  <b>Personal Care level II or 2</b>  <b>PCII or 2</b>  <b>Physical Therapy Services</b> </p>

		<b>Physical Therapy</b> <b>PT</b> <b>Prescribed Drugs</b> <b>Drugs</b> <b>Prevocational Services</b> <b>Prevocational</b> <b>PreVoc.</b> <b>Provocation</b> <b>Private Vehicle modifications</b> <b>Vehicle modifications</b> <b>Vehicle mods.</b> <b>Physiological services</b> <b>Psychological</b> <b>Psych. Services</b> <b>Residential Habilitation</b> <b>Residential Hab.</b> <b>Residential</b> <b>Respite Care</b> <b>Respite</b> <b>Respite Care Services</b> <b>Specialized Medical Equipment, Supplies and Assistive Technology</b> <b>Specialized Medical Equipment, Supplies &amp; Assistive Technology</b> <b>Assistive Technology</b> <b>Speech-Language Pathology</b> <b>Speech Therapy</b> <b>Speech Services</b> <b>Speech Therapy Services</b> <b>Supported Employment Services</b> <b>Supported Employment</b>  <b>Source: MR/RD Waiver Manual</b>
G9-03	The Freedom Choice Form is Present.	<p>Review the record (this is not to include the “back-up” record) to ensure that Freedom of Choice Form is present in the record. The form must be checked to indicate choice of waiver services in the community over institutionalization and signed by the waiver participant or his/ her legal guardian. If the waiver participant is over age 18 and not adjudicated incompetent but is physically unable to sign the form, the form and the contact notes should indicate why signed choice was not obtained. If the person has reached the age of majority since waiver enrollment and has not been adjudicated incompetent, the waiver participant must either date and sign a new Freedom of Choice form or sign and date the original Freedom of Choice form documenting choice of waiver services in the community over institutionalization. This should be completed within 30 days of their 18<sup>th</sup> birthday.</p> <p>Source: MR/RD Waiver Manual</p>
G9-04	The Freedom of Choice Form is signed prior to waiver enrollment.	<p>Review Freedom of Choice Form and waiver enrollment date.</p> <p>Source: MR/RD Waiver Manual</p>

<b>G9 MR/RD Waiver</b>		<b>GUIDANCE</b>
<b>G9-05 R</b>	The most current Level of Care Determination is dated within 365 days of the last Level of Care determination and is completed by the appropriate entity.	<p>Review the most recent and previous Level of Care evaluations to ensure that recertification occurred within 365 days. Initial ICF/MR evaluations are requested from SCDDSN's Consumer Assessment Team. Re-evaluations are completed by Service Coordinators for all consumers except for those persons whose eligibility determination is "Time-Limited", "At Risk" or "High Risk". The Consumer Assessment Team must complete these evaluations. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. The date the Level of Care re-evaluation is completed is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2003 the effective date would be 7/3/03 with an expiration date of 7/2/04.</p> <p><b>Source: MR/RD Waiver Manual</b></p>
G9-06	The current Level of Care is supported by the assessments and documents indicated on the Level of Care determination.	<p>Review the most current LOC determination and compare it to information in the assessments/documents referenced as sources for the Level of Care evaluation to determine if documentation supports the current Level of Care assessment.</p> <p><b>Source: MR/RD Waiver Manual</b></p>
G9-07	The Current Level of Care is completed appropriately.	<p>Review the most current LOC determination to ensure all sections of the LOC Determination Form are complete. To be valid, a yes or no score must be indicated for all items.</p> <p>Note: If this Indicator is found to be 'Not Met', G9-05 will be determined 'Not Met' as well.</p> <p><b>Source: MR/RD Waiver Manual</b></p>
G9-08	When the person refused a MR/RD Waiver service(s), the risks associated with refusing the service(s) were discussed.	<p>Review contact notes and other record documentation along with all Plans completed during the review period to determine if a person participating in the MR/RD Waiver refused a MR/RD Waiver service. If a service was refused, review record to locate documentation that the risks associated with refusing the service were discussed.</p> <p><b>Source: MR/RD Waiver Manual</b></p>
G9-09	Documentation is present verifying that a choice of provider was offered to the person/ family for each MR/RD Waiver service.	<p>Review the contact notes and the person's Plan to determine if the person was given a choice of provider of service each time a service need was identified/ authorized.</p> <p><b>Source: MR/RD Waiver Manual</b></p>
G9-10	Acknowledgment of Rights and Responsibilities (MR / RD Form 2) is completed with the annual Plan.	<p>Review the record to ensure that the Acknowledgement of Rights and Responsibilities is present. Review signature dates (signed by person or legal guardian, if applicable) on the current and previous forms to ensure they have been completed with the annual Plan.</p> <p><b>Source: MR/RD Waiver Manual</b></p>
G9-11	MR/RD Waiver services are provided in accordance with the service definitions	<p>Review Service definitions in the MR/RD Waiver document for each service that the person is receiving. Review the person's Plan, contact notes and relevant service assessments to ensure that services are being provided according to the definitions.</p> <p><b>Source: MR/RD Waiver Manual</b></p>
<b>G9-12 R</b>	<b>If Nursing Services are provided, an order from the physician is present and coordinates with the Authorization of Services Form (MR/RD Form A-12).</b>	<p><b>Review record to ensure that a doctor's order is available and is consistent with the amount and type of Nursing Services authorized for the person.</b></p> <p><b>Source: MR/RD Waiver Manual</b></p>

<b>G9 MR/RD Waiver</b>		<b>GUIDANCE</b>
G9-13	If Personal Care Aide Services (II) are provided to children under the age of 21, an order is present from the physician for Personal Care Aide Services.	Review record to ensure that a physician's order is available  Source: MR/RD Waiver Manual
<b>G9-14 R</b>	<b>Evidence that services are not available under the VR program is present if the individual receives Supported Employment or Prevocational services.</b>	<b>Review the record to determine if the individual is receiving Supported Employment or Prevocational services through the MR/RD Waiver. If either service is received, review record to locate documentation supporting that this service is not available under a VR program for the person.</b>  <b>Source: MR/RD Waiver Manual</b>
G9-15	MR/RD Waiver services are received at least every 30 days.	Review service notes and Plan to ensure that the person has received or is receiving at least one MR/RD Waiver service every 30 days during the review period. A service must be received at least every 30 days. If at least one service was not received every 30 days, the person should have been dis-enrolled from the Waiver.  Source: MR/RD Waiver Manual
G9-16	Service needs outside the scope of Waiver services are identified in Plans and addressed.	Review the Plan, contact notes, and other documentation in the record to ensure that the Service Coordinator has identified and addressed all service needs regardless of the funding source.  Source: MR/RD Waiver Manual
G9-17	Authorization forms are completed for services as required, prior to service provision.	Review the person's budget and Plan to ensure that Authorization for Services forms are present and note a "start date" for services that is the same or after the date of the Service Coordinator's signature. Authorization forms are required for all services except Prescribed Drugs, Adult Vision Services, Adult Dental Services, and an Audiological Evaluation.  Source: MR/RD Waiver Manual
G9-18	Contact notes reflect monitorship within the first month of the start of an ongoing MR/RD Waiver service or provider change to include the effectiveness, frequency, duration, benefit, usefulness, and person/family's satisfaction with the service.	Review the Plan, contact notes, and service authorizations to determine if the person began receiving a new ongoing service and/or the person changed providers of a previously received ongoing service. If so, review contact notes, the Plan and other documentation in the record to determine if service or provider change was monitored within 1 month and documentation regarding effectiveness, frequency, duration, benefit, usefulness, and person's or his/her legal guardian's satisfaction with the service.  Source: MR/RD Waiver Manual
G9-19	Contact notes reflect monitorship within the second month from the start of an ongoing MR/RD Waiver service or provider change to include the effectiveness, frequency, duration, benefit, usefulness, and person / family's satisfaction with the service.	Review the Plan, contact notes, and service authorizations to determine if the person began receiving a new ongoing service and/or the person changed providers of a previously received ongoing service during the review period. If so, review contact notes to determine if service or provider change was monitored within the second month and documentation regarding the effectiveness, frequency, duration, benefit, usefulness, and person's or his/her legal guardian's satisfaction with the service.  Source: MR/RD Waiver Manual

G9	MR/RD Waiver	GUIDANCE
G9-20	Contact notes reflect monitorship as often as needed but at least quarterly regarding all ongoing MR/RD Waiver services to include the effectiveness, frequency, duration, benefit, usefulness, and person / family's satisfaction with the service.	<p>Review contact notes, the Plan, and other documentation in the records to determine if all Waiver services are monitored at least quarterly to include the effectiveness, frequency, duration, benefit, usefulness, and person's or his/ her legal guardian's satisfaction with the service. The actual requirement is for monitorship of each service as needed but at least quarterly.</p> <p>Source: MR/RD Waiver Manual</p>
G9-21	Contact notes reflect monthly monitoring for those recipients only receiving 2 or less MR/RD Waiver services to include the effectiveness, frequency, duration, benefit, and usefulness of the service.	<p>Review the Plan, contact notes, MR/RD Waiver budget and service authorizations to determine how many Waiver services the person is receiving. If the person is receiving 2 or less MR/RD Waiver services, review the contact notes to ensure that all MR/RD Waiver services are monitored monthly and that the monitorship includes effectiveness, frequency, duration, benefit, and usefulness of the service.</p> <p>Source: MR/RD Waiver Manual</p>
G9-22	Contact notes reflect on-site monitorship of Adult Day Health, Attendant Care, Personal Care, Nursing and/or Companion Services, while service is being provided. This monitorship must occur within 1 month of the start of service or provider change and once yearly unless otherwise noted by supervisor exception and documented approval.	<p>Review contact notes, the Plan, and other documentation in the record to determine if documentation is available to support that an on-site visit was provided as required for each applicable Waiver service the person is receiving. If an exception is noted, documentation must be available noting why and must be only for extreme circumstances (i.e., the service is only provided in extremely early or late hours). This monitorship should include the effectiveness, frequency, duration, benefit, usefulness, and person's or his/ her legal guardian's satisfaction with the service.</p> <p>NOTE: If service is provided before 7 am or after 9 pm, on-site monitorship is not required.</p> <p>Source: MR/RD Waiver Manual</p>
G9-23	Contact notes reflect monitorship with the recipient within 2 weeks of the one-time service and reflect that the service was received.	<p>Review contact notes, the Single Plan and service authorizations to determine if the person received any one-time services during the review period. If so, review the contact notes to determine if the service was monitored within 2 weeks of receipt to determine if the person received the service and documentation is present noting the usefulness, benefit, effectiveness and person's or his/ her legal guardian's satisfaction with the service.</p> <p>Source: MR/RD Waiver Manual</p>
G9-24	Services notes reflect an on-site monitorship during the construction phase for environmental modifications and within 2 weeks of completion.	<p>Review contact notes, the Plan, and service authorizations to determine if an environmental modification was completed during the review period. If so, review the contact notes to determine if the modification was seen by the Service Coordinator during both the construction phase and within 2 weeks of the completion date. Also review documentation to ensure support of the effectiveness, usefulness and benefit of the service along with the person's or his/ her legal guardian's satisfaction.</p> <p>Source: MR/RD Waiver Manual</p>
G9-25	Contact notes reflect an on-site monitorship for private vehicle modifications within 2 weeks of completion.	<p>Review contact notes, the Plan, and service authorizations to determine if a private vehicle modification was completed during the review period. If so, review the contact notes to determine if the modification was seen by the Service Coordinator within 2 weeks of the completion date and documentation is available to support the effectiveness, usefulness and benefit of the service along with the person's or his/ her legal guardian's satisfaction.</p>

		Source: MR/RD Waiver Manual
<b>G9</b>	<b>M/RD Waiver</b>	<b>GUIDANCE</b>
G9-26	Contact notes reflect an on-site monitorship, if hearing aid is provided, within 2 weeks of the person receiving the aide(s).	<p>Review contact notes, the Plan and service authorizations to determine if a hearing aid was provided during the review period. If so, review the contact notes to determine if monitorship was provided on-site by the Service Coordinator within 2 weeks of the date of receipt and documentation is available to support the usefulness and effectiveness of the service along with the person's or his/her legal guardian's satisfaction with the service.</p> <p>Source: MR/RD Waiver Manual</p>
G9-27	For any one-time assistive technology item costing 1500.00 or more, the Service Coordinator has made an on-site visit to observe the item and to document the item's usefulness and effectiveness.	<p>Review contact notes, the Plan and service authorizations to determine if any one-time assistive technology item costing over \$1500.00 was provided during the review period. If so, review the contact notes to determine if the item was seen in the recipient's possession by the Service Coordinator and documentation is available to support the usefulness and effectiveness of the service along with the person's or his/her legal guardian's satisfaction with the service.</p> <p>Source: MR/RD Waiver Manual</p>
G9-28	The Person/Legal Guardian was notified in writing regarding any denial, termination, reduction, or suspension of MR/RD Waiver services with accompanying appeals information.	<p>Review contact notes to determine if during the review period any Waiver services were reduced, suspended, terminated, or denied. If this is noted, then review the contact notes to determine if the person or legal guardian was notified in writing regarding the denial, suspension, termination or reduction of the service and provided with the appropriate appeals process.</p> <p>Note: If the person requests to discontinue, suspend, or reduce the service, this Indicator is N/A</p> <p>Source: MR/RD Waiver Manual</p>

G10 PDD Program		GUIDANCE
G10-01	PDD Waiver participants must meet all eligibility criteria	<p>Review the record to determine if the child meets the criteria for services through the PDD Program:</p> <ul style="list-style-type: none"> <li>• Be ages 3 through 10 years.</li> <li>• Diagnosed with a PDD by age eight years. The diagnosis must be made by a qualified, licensed or certified diagnostician. Children who are currently eligible for DDSN under the Autism Division must meet these criteria.</li> <li>• Meet Medicaid financial criteria or provide documentation of financial ineligibility for Medicaid.</li> <li>• Meets ICF/MR Level of Care medical criteria (as determined by the DDSN Consumer Assessment Team for this program).</li> </ul> <p>Note: Children who do not meet ICF/MR Level of Care, but meet all other eligibility requirements may receive services outside the waiver through the State Funded PDD program if funding is available.</p> <p>Source: PDD Waiver Manual</p>
G10-02	The Freedom of Choice Form is present for PDD Waiver recipients.	Review the record to ensure that the Freedom of Choice form is present in the record. The form must be "checked" to indicate choice of Waiver services in the community over institutionalization and signed by the child's parent/legal guardian.
G10-03	The Freedom of Choice is signed prior to Waiver enrollment.	Review Freedom of Choice form and Waiver enrollment date.
G10-04	The Initial Level of CARE is present.	Review the initial LOC determination to determine if it was completed prior to or on the date of Waiver enrollment.
<b>G10-05 R</b>	<b>The most current Level of Care Determination is dated within 365 days of the last Level of Care Determination and is completed by the Consumer Assessment Team.</b>	<b>Review the most recent and previous Level of Care evaluations to ensure that recertification occurred within 365 days. Initial ICF/MR evaluations are requested from SCDDSN's Consumer Assessment Team. The Case Manager must submit a packet of information to the team to determine LOC. Reevaluations are completed by the Consumer Assessment Team. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. The date the Level of Care Re-evaluation is completed is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2003 the effective date would be 7/3/03 with an expiration date of 7/2/04.</b>
G10-06	Documentation is present verifying that a choice of providers was offered to the child's parents/legal guardians for each PDD service.	Review the contact notes, the child's Plan and other file documents to determine if the parents/legal guardians were given a choice of provider of service before the service (i.e. Case Management and EIBI) was authorized.
G10-07	The Acknowledgment of Rights and Responsibilities is completed with the annual Plan.	Review the record to ensure that the Acknowledgement of Rights and Responsibilities is present. Review signature dates on the current and previous forms to ensure they have been completed with the annual Plan.
G10-08	PDD services are provided in accordance with the service definitions.	Review Service definitions in the PDD Manual for each service that the child is receiving. Review the child's Plan, contact notes and relevant service authorizations to ensure that services are being provided according to the definitions.
G10-09	For PDD Waiver recipients, PDD Waiver services are received at least every 30 days.	Review services notes and the Plan to ensure that the person has received or is receiving at least one Waiver service every 30 days during the review period. A service must be received at least every 30 days. If at least one service was not received every 30 days, the person should have been disenrolled from the Waiver.
G10-10	Authorization forms are completed for services, as required, prior to service provision.	Review the child's budget and Plan to ensure that Authorization for Services forms are present and note a "start date" for services that is the same or after the date of the Case Manager's signature. Authorization forms are required for all services.

G10	PDD Program	GUIDANCE
G10-11	The Person/Legal Guardian was notified in writing regarding any denial or termination of PDD services with accompanying appeals information.	Review contact notes to determine if during the review period any Waiver services were terminated or denied. If this is noted, then review the contact notes to determine if the parent/legal guardian was notified in writing regarding the denial or termination of the service and provided with the appropriate appeals process.
G10-12	The Plan clearly includes and justifies the need for all PDD Waiver services received.	Review the Plan, service authorizations to ensure that all PDD Waiver services are included and supported by assessed need in the child's Plan. Services should be identified and provided according to PDD Waiver service definitions.
G10-13	The record must reflect that the child's parent/legal guardian was offered the opportunity to participate in planning.	Review the Case Management record to ensure the child's parent/legal guardian was afforded the opportunity to participate in planning. This should be demonstrated in the record by inviting the child's parent/legal guardian to meet to discuss plans, by scheduling the meeting (If a meeting is chosen) at a time and location that facilitated participation, by soliciting input prior to the actual meeting if attendance is not possible, or by allowing participation in the meeting by phone or other means. The requirement is that the opportunity be afforded, not that participation occur.
G10-14	The parent/legal guardian was provided a copy of the Plan.	Review the service notes to verify that the child's parent/legal guardian was provided a copy of the Plan.
G10-15	The Plan is monitored at least quarterly (Quarterly Plan Review).	The Plan is monitored at least quarterly (Quarterly Plan Review). Review all Plans in effect during the review period to determine if all needs and interventions were monitored as often as needed, but at least quarterly and to ensure that needs were implemented as prescribed in the Plan. Documentation for each need and intervention should include recommendations for continued implementation, revision or discontinuation.
G10-16	Case Managers who serve children in the PDD Program must meet the minimum requirements for the position.	Identify the Case Managers who serve PDD recipients. Determine from personnel records if the minimum requirements for employment were met. Refer to the contract between SCDHHS and SCDDSN pertaining to The Purchase and Provision of Home and Community-Based Pervasive Developmental Disorder Waiver Services.
G10-17	Records include documentation of verification that Case Managers are free from tuberculosis.	<p>Review TB results of each Case Manager from personnel sample. Check documentation for the following:</p> <ul style="list-style-type: none"> <li>• Must have a PPD Tuberculin skin test no more than ninety (90) days prior to employment, unless a previously positive reaction can be documented. Must have a PPD Tuberculin skin test no more than ninety (90) days prior to employment, unless a previously positive reaction can be documented.</li> <li>• In lieu of a PPD tuberculin test no more than 90 days prior to employment, a new employee may provide certification of a negative tuberculin skin test within the 12 months preceding the date of employment and certification from a licensed physician or local health department TB staff that s/he is free of the disease.</li> <li>• Employees with negative tuberculin skin tests shall have an annual tuberculin skin test.</li> <li>• New employees who have a history of tuberculosis disease and have had adequate treatment shall be required to have certification by a licensed physician or local health department TB staff (prior to employment and annually) that they are not contagious. Regular employees who are known or suspected to have tuberculosis shall be required to be evaluated by a licensed physician or local health department TB staff, and must not return to work until they have been declared non-contagious.</li> </ul> <p>Refer to the contract between SCDHHS and SCDDSN pertaining to The Purchase and Provision of Home and Community-Based Pervasive Developmental Disorder Waiver Services, Appendix B, Case Management Services, Conditions of Participation, item # 6.</p>

G10	PDD Program	GUIDANCE
G10-18	Case Managers will provide at least 1 monthly contact with the EIBI service providers and/or family to determine progress/lack of progress on established goals and/or participant satisfaction with EIBI providers.	<p>Review contact notes in the records to determine if the parents and/or provider has been contacted monthly.</p> <p>Review established goals and monthly progress reports received from the provider to determine progress or the lack of progress.</p> <p>Review contact notes to determine if Case Manager received complaints from families about provider services and, if the Case Manager discussed the concerns with the provider.</p>
G10-19	Case Managers will contact the child's family quarterly.	<p>Review contact notes and other documentation to determine:</p> <ul style="list-style-type: none"> <li>• If the family received quarterly contact from the Case Manager</li> <li>• If the entire Support Plan was reviewed and discussed</li> </ul> <p>If the most recent EIBI service provider quarterly data report was reviewed and discussed.</p>
G10-20	Case Managers will have at least one face-to-face contact visit with the child and their family annually.	Review service notes in the Case Management record to determine if the child served has received face-to-face contact by the Case Manager at least once per Plan year during each 365-day period.
<b>G10-21 R</b>	<b>Case Managers will ensure the Plan is developed, reviewed and approved every 365 days or more often if needed.</b>	<p><b>Review current Plan in the child's record. A current Plan must be present and signed by the Case Manager. A current Plan is defined as one completed within the last 365 days. A Plan must be completed:</b></p> <ul style="list-style-type: none"> <li>• <b>Within 365 days of the last plan</b></li> <li>• <b>Before PDD Services are authorized or provided.</b></li> </ul>
G10-22	Case Managers are responsible for preparing and submitting all documents needed for timely determination of the ICF/MR LOC by the Consumer Assessment Team. The most current Level of Care Determination is dated within 365 days of the last Level of Care Determination.	Review the most recent and previous Level of Care evaluations to ensure that recertification occurred within 365 days. Initial ICF/MR evaluations are requested from SCDDSN's Consumer Assessment Team. The Case Manager must submit a packet of information to the team to determine LOC. Reevaluations are completed by the Consumer Assessment Team. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. The date the Level of Care Re-evaluation is completed is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2003 the effective date would be 7/3/03 with an expiration date of 7/2/04.
G10-23	Case Managers must document all activities in the child's record.	Contact notes must include the date and time, individual(s) involved, description of the discussion, event or activity, and any necessary action taken. Backdating is prohibited. Handwritten entries must be documented using blue or black ink. Word processed documents must be initialed and dated in ink by the Case Manager who performed the activity.
G10-24	Case Managers must document the date on which the child's referral was first received and the date all actions taken thereafter	Review contact notes to determine if the family's initial choice of a Case Management provider was documented. Review the records for the Choice of Provider form and ensure it was signed and dated by the child's parents/legal guardians. Review the notes to ensure all subsequent entries are dated.
G10-25	Case record documentation must reflect that the child's parents were given a choice from all qualified EIBI providers in the state.	Review the contact notes and the person's Plan to determine if the parent/legal guardian was given a choice of EIBI providers before services were authorized.
G10-26	Case Managers must utilize required forms, completed properly, and they must include the required signatures	Review the PDD Manual including the index of forms. Compare this to the actual documents found in the participant's file to determine proper usage. Review all documents for signatures and dates as required.

G10	PDD Program	GUIDANCE
G10-27	Case Manager's must assure and records must reflect that each child's parent has been fully informed about how to file a complaint.	Review records to ensure that parents are provided information on the Reconsideration/Appeals Process at least annually and at any relevant action such as termination or denial of services.
G10-28	Case Managers are required to attend all SCDDSN in-service/trainings related to the provision of case management for PDD waiver recipients.	Obtain training calendar from Case Management supervisor. Look in the training section of the personnel records of the selected employee for documentation of attendance at training sessions.
G10-29	Case Management records are maintained and include required information.	<p>Review the Case Management record to determine if records include the following:</p> <ul style="list-style-type: none"> <li>• A current Single/Support Plan (After 7/1/07 the Support Plan will be used)</li> <li>• Current IEP (for school age children)</li> <li>• Service Notes (when reviewing service notes, check to make sure that service notes are typed or handwritten in black or dark blue ink, legible, in chronological order, entries dated and signed with the date, Service Coordinator's name and title or initials (a signature/initial sheet must be maintained at the Service Coordination provider's office), if abbreviations or symbols are used, there is a list of any abbreviations or symbols maintained at the Service Coordination provider's office, persons referenced are identified by their relationship to the person receiving services either at least once on each page or on a separate list located in each record, proper error correction procedures are followed if errors have occurred and no correction fluid or erasable ink was used)</li> </ul> <p>Submitted by the EIBI Consultant</p> <ul style="list-style-type: none"> <li>• Progress reports: must be submitted monthly and demonstrate/document that drills are conducted as scheduled</li> <li>• Data reports: must be submitted quarterly and contain cumulative graphs of target areas demonstrating progress or areas of concern</li> <li>• Assessment of Basic Language and Learning Skills (ABLLS): must be submitted semi-annually per the initial assessment date</li> <li>• Peabody Picture Vocabulary Test (PPVT) and Vineline: must be submitted annually per the initial assessment date</li> </ul>
G10-30	Providers must ensure that each employee meets the requirements for the position in which they serve.	<p>Review personnel files for documentation, credentials and written evidence to support and demonstrate that employees meet the minimum requirements for the position in which they serve.</p> <p>All individuals who serve as the Applied Behavior Analysis Consultant must meet the following requirements:</p> <ul style="list-style-type: none"> <li>• A master's degree in behavior analysis, education, psychology, or special education; and</li> <li>• Current certification by the Behavior Analyst Certification Board as a Board Certified Behavior Analyst (BCBA); and</li> <li>• At least one year of experience as an independent practitioner; and</li> <li>• Successfully complete the initial approval process which includes an interview and the submission of a Work Sample that is reviewed and critiqued for competency by the DDSN interview team or</li> <li>• A bachelor's degree in behavior analysis, education, psychology, or special education; and</li> <li>• Current certification by the Behavior Analyst Certification Board as a Board Certified Associate Behavior Analyst (BCABA); and</li> <li>• At least two years of experience as an independent practitioner, and</li> <li>• Successfully complete the initial approval process which includes an interview and the submission of a Work Sample that is reviewed and critiqued for competency by the DDSN interview team; or</li> <li>• A bachelor's degree in behavior analysis, education, psychology, or</li> </ul>

		<p>special education; and</p> <ul style="list-style-type: none"> <li>• At least three years of experience as an independent practitioner; and</li> <li>• Successfully complete the initial approval process which includes an interview and the submission of a Work Sample that is reviewed and critiqued for competency by the DDSN interview team.</li> </ul> <p>All individuals who serve as Lead Therapist must meet the following requirements unless an exception has been granted by DDSN:</p> <ul style="list-style-type: none"> <li>• A bachelor's degree in behavior analysis, education, psychology, or special education; and</li> <li>• Has at least 500 hours of supervised line therapy or supervised experience in implementing behaviorally based therapy models consistent with best practices and research on effectiveness, for children with Pervasive Developmental Disorder to include autism and Asperger's disorder.</li> <li>• If an exception has been granted, there must be written evidence from DDSN.</li> </ul> <p>All individuals who serve as Line Therapists must meet the following requirements:</p> <ul style="list-style-type: none"> <li>• Be at least 18 years old and a high school graduate;</li> <li>• Be able to speak, read and write English;</li> <li>• Have documentation of receiving the required training as listed below prior to providing a service: <ul style="list-style-type: none"> <li>a. Current First Aid Certification (must be renewed at least every three years)</li> <li>b. Current CPR Certification (must be renewed annually)</li> <li>c. Confidentiality, Accountability, and Prevention of Abuse and Neglect</li> <li>d. At least 12 hours of training in the implementation of applied behavior analysis to include at least 3 hours of autism and PDD specific training</li> </ul> </li> <li>• Have documentation of receiving the required annual in-service training of at least 5 hours in the implementation of applied behavior analysis, autism or PDD specific training.</li> <li>• Have documentation of a clear background check conducted by the provider prior to providing a service and at least annually thereafter in the following areas: <ul style="list-style-type: none"> <li>a. Not listed in the DSS Child Abuse Central Registry</li> <li>b. Have no felony convictions as determined by an officially obtained SLED report</li> <li>c. Provide a copy of current, valid driver's license (If no driver's license submit a copy of an Official State ID Card)</li> <li>d. PPD Tuberculin Test</li> </ul> </li> </ul>
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G10	PDD Program	GUIDANCE
G10-31	There must be documentation those individuals/entities that are on the qualified provider list for EIBI services completed the initial approval process.	<p>All EIBI providers should have the following documentation on file for the initial approval process:</p> <ul style="list-style-type: none"> <li>• A completed Early Intensive Behavior Intervention Provider Application (must be signed and dated) and all required attachments (e.g. a current curricula vita and 1) an educational / behavioral testing evaluation (preferably the ABLLS), 2) an educational program or program example to include data / graphs and progress updates and, 3) a Behavioral Support Plan to include a Functional Assessment for which you have written / developed and implemented for an individual with a Pervasive Developmental Disorder.</li> <li>• The Provider Approval Letter</li> <li>• The Provider Pre-Enrollment Information for Participation in the Pervasive Developmental Disorder Waiver Program form</li> <li>• The W-9</li> <li>• The Medicaid Enrollment Form</li> <li>• The EIBI Certification Letter</li> </ul>
G10-32	Individuals/entities that become approved providers of EIBI services submit required data to the child's Case Manager and the Autism Division within the timeframes specified.	<p>Review the child's records to determine the date services began and look for data that corresponds to that date.</p> <ul style="list-style-type: none"> <li>• Progress reports: must be submitted monthly and demonstrate/document that drills are conducted as scheduled</li> <li>• Data reports: must be submitted quarterly and contain cumulative graphs of target areas demonstrating progress or areas of concern</li> <li>• Assessment of Basic Language and Learning Skills (ABLLS): must be submitted semi-annually per the initial assessment date</li> <li>• Peabody Picture Vocabulary Test (PPVT) and Vineline: must be submitted annually per the initial assessment date</li> </ul>
G10-33	EIBI providers keeps records secure and information confidential.	<p>Determine if records are maintained in secure locations. Look for evidence that confidential information is kept confidential. Consider the following:</p> <ul style="list-style-type: none"> <li>• Are any records in public areas or in areas that are not secure including lying on desks in empty offices, etc?</li> <li>• Is personal information in conspicuous locations or posted in common areas?</li> <li>• Is information about one person found in another person's file?</li> <li>• Are records/information provided or released without consent including by the phone?</li> <li>• Are fax machines in public areas and incoming/outgoing information left by/around the machine?</li> <li>• Are staff heard discussing information about clients in restrooms, hallways, etc. in a manner that clearly identifies the person about whom they are speaking?</li> </ul>